

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6658

CERTIFICATE OF DEATH

Reg. Dist. No. 131

06629

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) X Frederick		LENGTH OF STAY (in this place) 1 Day		CITY (If outside corporate limits, write RURAL and give nearest town) OR Frederick-Rural-R.D.#6, X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Frederick Co. Chronic Hospital				STREET ADDRESS (If rural give location) Reich's Ford Radd			
3. NAME OF DECEASED: (First) (Middle) (Last) ROBERT LEE AYLOR				4. DATE (Month) (Day) (Year) OF DEATH: July 2, 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower		8. DATE OF BIRTH: October 19, 1872	
9. AGE last birthday: 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER		11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		16. SOCIAL SECURITY No. 223-36-5326		17. INFORMANT & ADDRESS: Lewis W. Aylor, Frederick, R.F.D.#6, Md.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Coronary Thrombosis							2 hrs
ANTECEDENT CAUSE (B) Chronic Myocarditis							5 yrs +
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Atherosclerosis							5 1/2 yrs +
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 2, 1955, to July 2, 1955 that I last saw the deceased alive on July 2, 1955, and that death occurred at 1:15AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
				Frederick, Maryland		7/2/1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 4, 1955		Walkers Chapel Cemetery		Orange, Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
2 July 1955		Elizabeth B. Heck		M. R. Etchison & Son, Frederick, Maryland			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 7 1965

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06630

6653

## CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH- COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <b>Lewistown</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Lewistown</b> <input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>		STREET ADDRESS (If rural, give location) <b>1</b>	
3. NAME OF DECEASED (Type or Print) <b>JACOB HENRY BAER</b>		4. DATE OF DEATH (Month) <b>July</b> (Day) <b>1</b> (Year) <b>1955</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Mar. 9, 1870</b>
9. AGE last birthday <b>85 yrs.</b>		10. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Henry Baer</b>		14. MOTHER'S MAIDEN NAME <b>Annie Sophia Ramsburg</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY No. <b>none</b>	
17. INFORMANT <b>Ray Baer, Lewistown, Md.</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.0 Immediate cause (a) <b>Acute Pulmonary Edema</b>		
Antecedent cause(s) (b) <b>Arteriosclerotic Heart Disease</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		5 yrs.
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Generalized arteriosclerosis</b>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Aug 2**, 19**54**, to **July 1**, 19**55**, that I last saw the deceased alive on **June 26**, 19**55**, and that death occurred at **12 12** **EDST** P.m., from the causes and on the date stated above.

SIGNATURE **Barry J. Plunkett, Jr., M.D.** ADDRESS **Walkersville, Maryland** DATE SIGNED **July 2, 1955**

23. BURIAL, CREMATION REMOVAL (Specify) **Burial** DATE THEREOF **July 4, 1955** NAME OF CEMETERY OR CREMATORY **Utica Cemetery** LOCATION (City, town, or county) (State) **Utica, Fred. Co. Md.**

DATE REC'D BY LOCAL REG. **July 4, 1955** REGISTRAR'S SIGNATURE **Blanche S. Eyles** 24. FUNERAL DIRECTOR **M. L. Creager & Son, Thurmont, Md.** ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 81

JUL 6 1955

RECEIVED

6626

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE New York		COUNTY Monroe	
CITY (If outside corporate limits, write RURAL and give nearest town) 11 <del>TOWN</del> Frederick		LENGTH OF STAY (in this place) 4 weeks		CITY (If outside corporate limits, write RURAL and give nearest town) <del>TOWN</del> Rochester		69X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 69 Frederick Memorial Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) JOSEPH		(Middle) J.		(Last) BAIERL		4. DATE OF DEATH: (Month) July (Day) 8 (Year) 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: May 8, 1884		9. AGE last birthday: 71 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Priest		10b. KIND OF BUSINESS OR INDUSTRY: Ministry		11. BIRTHPLACE (State or foreign country): New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Michael Baierl				14. MOTHER'S MAIDEN NAME: Anna Kohlmaier			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mrs. Herbert Hartman - Rochester, New York			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Immediate cause Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.				(a) <i>Coronary artery sclerosis with acute myocardial infarction</i> DUE TO (b) DUE TO (c)			
Interval Between Onset And Death							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 2		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 8, 1955, to July 8, 1955, that I last saw the deceased alive on July 8, 1955, and that death occurred at 9:10 AM, from the causes and on the date stated above. SIGNATURE (Degree or title) DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL, (Specify) Removal		DATE THEREOF July 8, 1955		NAME OF CEMETERY OR CREMATORY Holy Sepulchre Cemetery		LOCATION (City, town, or county) (State) Rochester, New York	
DATE REC'D BY LOCAL REGISTRAR 8 July 1955		REGISTRAR'S SIGNATURE Elizabeth G. Heck		24. FUNERAL DIRECTOR C. E. Cline & Son - 8 East Patrick Street		ADDRESS Frederick, Maryland	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 11 1955

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6627 CERTIFICATE OF DEATH

06632

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Frederick</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	LENGTH OF STAY (If in this place) <b>18 hrs.</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>	<b>35</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Memorial Hospital</b>		STREET ADDRESS (If rural give location) <b>919 East "B"</b>	<b>1</b>
3. NAME OF DECEASED: (Type or Print) <b>Ms. Carrie A. Baker</b>		4. DATE OF DEATH: <b>July 9 1955</b>	
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, DIVORCED, OR SEPARATED: <b>Married</b>	8. DATE OF BIRTH: <b>7-8-1890</b>
9. AGE, last birthday: <b>65</b>		10. IF UNDER 1 YEAR: <b>1</b> MONTHS <b>9</b> DAYS <b>19</b> HOURS <b>55</b> MIN.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Home</b>	
11. BIRTHPLACE (State or foreign country): <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY: <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Crist Kimmel</b>		14. MOTHER'S MAIDEN NAME: <b>Henretta Kline</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>-</b>	
17. INFORMANT & ADDRESS: <b>E.L. Baker, Brunswick, Maryland</b>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
<b>420.0</b>		<b>1 day</b>	
Immediate cause (a) <b>Myocardial Infarction (Atherosclerotic) Rupture</b>		<b>6 mo.</b>	
Antecedent causes (s) (b) <b>Arteriosclerotic Heart Disease</b>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <b>Arteriosclerosis</b>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>-</b>			
19a. DATE OF OPERATION: <b>None</b>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <b>-</b>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>m.</b>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 8, 1955</b> , to <b>July 9, 1955</b> , that I last saw the deceased alive on <b>July 9, 1955</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above.			
SIGNATURE <b>A. G. Gorman</b>		ADDRESS <b>Frederick Md</b>	
DATE SIGNED <b>7/9/55</b>			
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>7-12-55</b>	
NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>July 9 55</b>		REGISTRAR'S SIGNATURE <b>Elizabeth B. Hark</b>	
24. FUNERAL DIRECTOR		ADDRESS <b>C.H. Feete and Bro. Brunswick, Maryland</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. E.

JUL 13 1955

RECEIVED

July 13 1955



## MARYLAND STATE DEPARTMENT OF HEALTH

06633

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 141

6660

1. PLACE OF DEATH COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Brunswick</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Brunswick</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Along C and O Canal</b>		STREET ADDRESS (If rural, give location) <b>Along C and O Canal</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>Carlton</b>	(Middle) <b>Leimond</b>	(Last) <b>Banks</b>
4. DATE OF DEATH	(Month) <b>July</b>	(Day) <b>7</b>	(Year) <b>1955</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>4/6/1905</b>
9. AGE last birthday <b>52</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
11. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ernest Linwood Banks</b>		14. MOTHER'S MAIDEN NAME <b>Sadie Avy Cannon</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT AND ADDRESS <b>Mrs. Sadie Banks Gilbert, Brunswick</b>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
322.1 Immediate cause (a) <b>acute alcoholism</b>		2 days	
Antecedent cause(s) (b) <b>Chronic</b>		20 years	
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>Home</b>	(CITY OR TOWN) <b>Brunswick, Md.</b>	(COUNTY) <b>Frederick</b> (STATE) <b>Md.</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <b>R. W. Barr</b>		DATE SIGNED <b>July 8 55</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>7-11-55</b>	NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>	LOCATION (City, town, or county) <b>Brunswick, Maryland</b> (State)
DATE REC'D BY LOCAL REG. <b>July 9-55</b>	REGISTRAR'S SIGNATURE <b>Pathryn N. Brown</b>	24. FUNERAL DIRECTOR <b>C.H. Feete and Bro, Brunswick, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 13 1955

RECEIVED

6628

MARYLAND STATE DEPARTMENT OF HEALTH

06634

# CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH - COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md.</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 CARVER Apts</u>		STREET ADDRESS (If rural, give location) <u>90 CARVER Apts</u>	
3. NAME OF DECEASED (Type or Print) <u>Chas. T. Barton</u>		4. DATE OF DEATH <u>July 17</u> 19 <u>55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 7 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pleasant View - Fred. Co. Md.</u>		12. CITIZENSHIP OF WHAT COUNTRY	
13. FATHER'S NAME <u>Edward Barton</u>		14. MOTHER'S MAIDEN NAME <u>Florence Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>217-10-9981</u>	
17. INFORMANT AND ADDRESS <u>Mary E. Barton 90 Carver Apts.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.1  
Immediate cause

(a) Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH  
7 minutes

## Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY Home

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY July 17 1955 INJURY OCCURRED While at work ☐ Not while at work ☐HOW DID INJURY OCCUR? Fred. Co. Md.

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

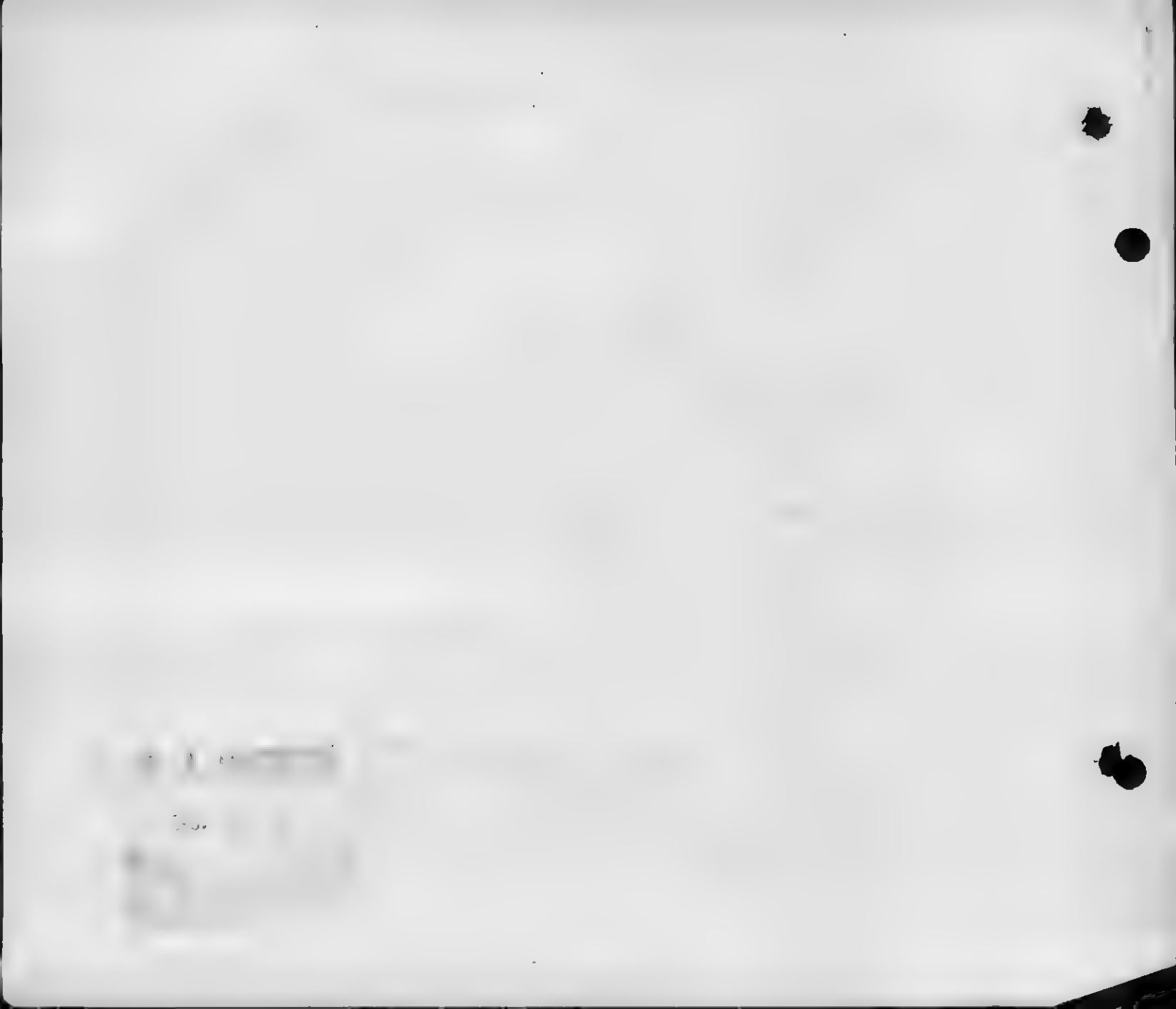
24. FUNERAL DIRECTOR

ADDRESS

19 July 1955Elizabeth H. HerbCharles E. Hicks Fred. Co. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6661

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06635

Item 21 Film G185 8-19-55 ams

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

Frederick  
 County Frederick  
 City or town Camp Detrick, Frederick, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 weeks  
 Hospital, institution, or street address where death occurred:  
Bldg. T-112, Camp Detrick, Frederick, Md.  
 How long to hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
California State Los Angeles County  
Long Beach City or town 43 X 3  
 (If outside city or town limits, write RURAL and give nearest town)  
2469 Pine Avenue Street No.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war service man—active duty

## 3. (a) FULL NAME

BAXTER, Sgt. Charles W. RA 39151634

## 3. (b) Social Security Number

Unk

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced divorced

6. (b) Name of husband or wife unknown

7. Birth date of deceased (mo., day, yr.) 9 April 1909 8. (c) If alive, give age years

8. AGE: 46 Years 3 Months 12 Days If less than one day hrs. min.

9. Birthplace Orange, Texas  
 (Town, county, and state)

10. Usual occupation soldier

11. Industry or business

12. Name deceased Charles W. Baxter

13. Birthplace

14. Maiden name deceased Alva Perez

15. Birthplace

16. Informant Same as item #1

17. Removal 23 July 1955  
 (Location, cremation, or removal. Widow) Date thereof (month) (day) (year)

Cemetery or crematory Evergreen CemeteryLocation Orange, Texas18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland

19. 22 July 1955  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

21. DATE OF DEATH 21 July 1955 0900

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 June 1955 to 21 July 1955 and that I last saw him alive on 15 July 1955

Immediate cause of death Acute cerebral edema

Due to Toxicology studies in progress  
Chronic & acute alcoholism

Due to

Other conditions Acute alcoholism

322 (Include pregnancy within 8 months of death)

Major findings of operation

Date of op.

Autopsy results Cerebral edema acute—not complete

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert E. Bryan

ROBERT E. BRYAN, Capt. MC  
 Address Post Surgeon Cp Detrick, Md. 22 Jul 55

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DOMINAR V



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06636

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

Item 9, Film G184 7-29-55 et

1. PLACE OF DEATH COUNTY <u>Frederick County</u> <u>Chronic Clinic</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> OR <u>Frederick</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Co. Chronic Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> OR <u>Frederick</u> STREET ADDRESS <u>31 S. Bentz St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Florence</u>	(First) <u>Ellis</u>	(Last) <u>Blair</u>	4. DATE OF DEATH (Month) <u>7</u> (Day) <u>22</u> (Year) <u>1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, <del>DECEASED</del> , (Specify)	8. DATE OF BIRTH <u>June 22, 1923</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Hotel</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>31</u> <u>32</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Mins.
13. FATHER'S NAME <u>John Pendleton</u>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT <u>Laura Pendleton</u>		14. MOTHER'S MAIDEN NAME <u>Laura Brown</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause <u>170X</u> (a) <u>Carcinoma breast</u>		<u>5 yrs.</u>
Antecedent cause(s) (b) <u>Generalized carcinoma</u>		<u>1 yr.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Lungs and abdominal peritoneum</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1954, to July 22, 1955, that I last saw the deceased alive on July 21, 1955, and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE Bernard Thompson, M.D. ADDRESS Frederick, Md. DATE SIGNED July 23, 1955

23. BURIAL OR CREMATION (Specify) Burial DATE 7-25-55 NAME OF CEMETERY OR CREMATORY FAIR VIEW LOCATION (City, town, or county) Frederick - Md. (State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Elizabeth S. Hersh 24. FUNERAL DIRECTOR Charles E. Hicks ADDRESS Frederick, Md.

BUREAU V. S.

JUL 1 1901

6629

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Virginia</u>	COUNTY <u>Loudoun</u>
CITY <u>Frederick</u> (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place) <u>Days</u>	OR <u>Lovettsville</u> (If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>		STREET ADDRESS (If rural) give location)	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>BABY DIANE PRAMHALL</u>		<u>July 22, 19 55</u>	
5. SEX: <u>Female</u>	6. COLOR <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>22 July 1955</u>
9. AGE last birthday: <u>3</u> yrs. <u>30</u> Months <u>3</u> Days <u>30</u> Hours <u>30</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Infant</u>	
10a. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Millard Bramhall</u>		14. MOTHER'S MAIDEN NAME: <u>Mae Hawkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Millard Bramhall, Lovettsville, Va.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Frythorblant's Foetus</u>		<u>From birth</u>	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2 July, 1955</u> to <u>22 July, 1955</u> , that I last saw the deceased alive on <u>2 July, 1955</u> , and that death occurred at <u>6:20 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>A. R. P. Jones</u>		DATE SIGNED <u>22 July 1955</u>	
ADDRESS <u>M.D. Frederick, Maryland</u>			
23. BURIAL CREMATION: <u>Burial</u>		DATE THEREOF <u>22 July 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Lovettsville, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>22 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Hark</u>	
24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5 A OVER

6663

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Anne Arundel County
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cullen	LENGTH OF STAY (in this place) 150 days.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater P.O., Woodland Beach	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital		STREET ADDRESS (If rural give location) 02X-1	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) Edward	(Middle) Emmott	(Last) Burton	OF DEATH: July 14, 1955
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower	8. DATE OF BIRTH: Sept. 16, 1873
9. AGE last birthday: 81 yrs		10. AGE last birthday: 81 yrs	
11. BIRTHPLACE (State or foreign country): District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: William E. Burton		14. MOTHER'S MAIDEN NAME: Amelia Handy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT & ADDRESS: Patient			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) Pulmonary Tuberculosis			9 months.
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from Feb. 14, 1955, to July 14, 1955 that I last saw the deceased alive on July 14, 1955, and that death occurred at 5:30 AM, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
J. B. Lyon		July 14, 1955	
M. D. Cullen, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
Burial	DATE THEREOF 7-16-55	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
		Ft. Lincoln Cem.	Pri. Geo. Co., Md.
DATE REC'D BY LOCAL REGISTRAR 7/14/55		24. FUNERAL DIRECTOR ADDRESS	
REGISTRAR'S SIGNATURE		W. W. Chambers, Riverdale, Md.	

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VS. A15

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VS. A15



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## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Frederick</u>		RURAL LENGTH OF STAY (in this place) <u>60 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		OR <u>Town</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Mem. Hospital</u>				STREET ADDRESS (If rural give location) <u>303 Rockwell Terrace</u>			
3. NAME OF DECEASED: (First) <u>Mr. Bessie</u> (Middle) <u>M.</u> (Last) <u>Clapp</u>				4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>7-20-1882</u>	
9. AGE last birthday: <u>72</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR		11. MONTHS: <u>72</u>		12. DAYS: <u>72</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Douglas H. Hargett</u>				14. MOTHER'S MAIDEN NAME: <u>Emma M. H. Hipp</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Frederick - Md.</u> <u>Mr. Robt. E. Clapp - 303 Rockwell Terrace -</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death <u>9 mo.</u>
<u>151X</u> Immediate cause (a) <u>Carcinoma of the Stomach with</u> DUE TO <u>Metastases to Liver and Spleen</u>		
Antecedent causes (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.</u> DUE TO		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Broncho Pneumonia</u>		2 days	
19a. DATE OF OPERATION: <u>Oct. 30, 1954</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of Stomach with Spleen Metastases</u>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	

TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 6, 1955</u> , to <u>July 2, 1955</u> , that I last saw the deceased alive on <u>July 2, 1955</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>H. A. Gearre</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>Frederick Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7-6-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	
LOCATION (City, town, or county) <u>Frederick - Md.</u>		(State) <u>Md.</u>		DATE REC'D BY LOCAL REGISTRAR <u>5 July 1955</u>	
REGISTRAR'S SIGNATURE <u>Elizabeth S. Heik</u>		24. FUNERAL DIRECTOR <u>C. E. Chine &amp; Son</u>		ADDRESS <u>Frederick - Md.</u>	

DOORAN V. S.

1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6631 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06640			
Item 2 by Phone to Baptist Home, 8/1/55 ams			
CERTIFICATE OF DEATH			
Reg. Dist. No. 131			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
<u>Frederick</u>	<u>3 Weeks</u>	<u>Baltimore/ Frederick</u>	<u>11</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural give location)
<u>Three Pines Nursing Home</u>		<u>Baptist Home of Maryland</u>	<u>1</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>JEAN MASON COLLUMS</u>		DATE OF DEATH: <u>July 28, 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>April 15, 1870</u>
9. AGE last birthday: <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William E. Mason</u>		14. MOTHER'S MAIDEN NAME: <u>Cornelia (last name unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mr. A.B. Collums, College Place, Frederick, Maryland</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Broncho-Pneumonia</u>			<u>3 days</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Heart Disease</u>			<u>1 yr</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis (Generalized)</u>			<u>Several years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Disease</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work Not while at work	
22. I hereby certify that I attended the deceased from <u>July 19, 1955</u> , to <u>July 28, 1955</u> , that I last saw the deceased alive on <u>July 27, 1955</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>A. A. Pearce</u>		DATE SIGNED <u>7/29/1955</u>	
ADDRESS <u>Frederick, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>July 30, 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Greenmont Cemetery</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>29 July 1955</u>		<u>Elizabeth B. Heck</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Mr. R. Etthison &amp; Son, Frederick, Maryland</u>			

WILSON V. S.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

06641

Reg. Dist. No. 134

6664

1. PLACE OF DEATH- COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural-Emmitsburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural-Emmitsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>R.D.1</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>RUTHELLA LYNN COOL</u>		4. DATE OF DEATH (Month) <u>JULY</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>3-17-1955</u>
9. AGE last birthday yrs. <u>3</u> Months <u>20</u> Days <u>20</u>		10. BIRTHPLACE (State or foreign country) <u>Frederick, Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel S. Cool</u>		14. MOTHER'S MAIDEN NAME <u>Geraldine Trent</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Emmitsburg, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Bronchopneumonia</u>			<u>Days</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>NONE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>R. W. Baer</u>		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7-9-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>		LOCATION (City, town, or county) (State) <u>Emmitsburg, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>July 8-1955</u>		24. FUNERAL DIRECTOR <u>S. L. Allison</u>	
		ADDRESS <u>Emmitsburg, Maryland</u>	

35318384

• **RESEARCH** •

177



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6665 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 18 Film G184 8-9-55 ams

06642

## CERTIFICATE OF DEATH

Reg. Dist. No. 147

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)				CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Rural - Mt. Airy</u>				OR TOWN <u>Rural - Mt. Airy</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
-				<u>Beyond end of Plainview Ave - Mt. Airy</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH: <u>July</u> <u>30</u> <u>1955</u>			
<u>Howard</u> <u>(None)</u> <u>Davis</u>							
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>October 19, 1938</u>	
				9. AGE last birthday: <u>16</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME: <u>Harry E. Davis</u>				14. MOTHER'S MAIDEN NAME: <u>Lorraine Butler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No.</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT & ADDRESS: <u>Mary Insley (Great Aunt) Mt. Airy</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>416X</u>							
IMMEDIATE CAUSE (A) <u>Rheumatic Heart Disease</u>						<u>7 years</u>	
DUE TO							
ANTECEDENT CAUSE (B) <u>Rheumatic Fever (not active)</u>						<u>9 years</u>	
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
-							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?					
M.							
22. I hereby certify that I attended the deceased from <u>March</u> , 1955, to <u>July</u> , 1955, that I last saw the deceased alive on <u>July 11</u> , 1955, and that death occurred at <u>10:15</u> A M, from the causes and on the date stated above.							
SIGNATURE <u>W.B. Culwell</u>				ADDRESS <u>Mt. Airy, Md</u>		DATE SIGNED <u>July 30, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-2-1955</u>		<u>Mt. Zion</u>		<u>Carroll Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Aug. 2, 1955</u>		<u>Blaise A. Runkles</u>					



1968  
AUG 4 1968  
MURRAY, E. B.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

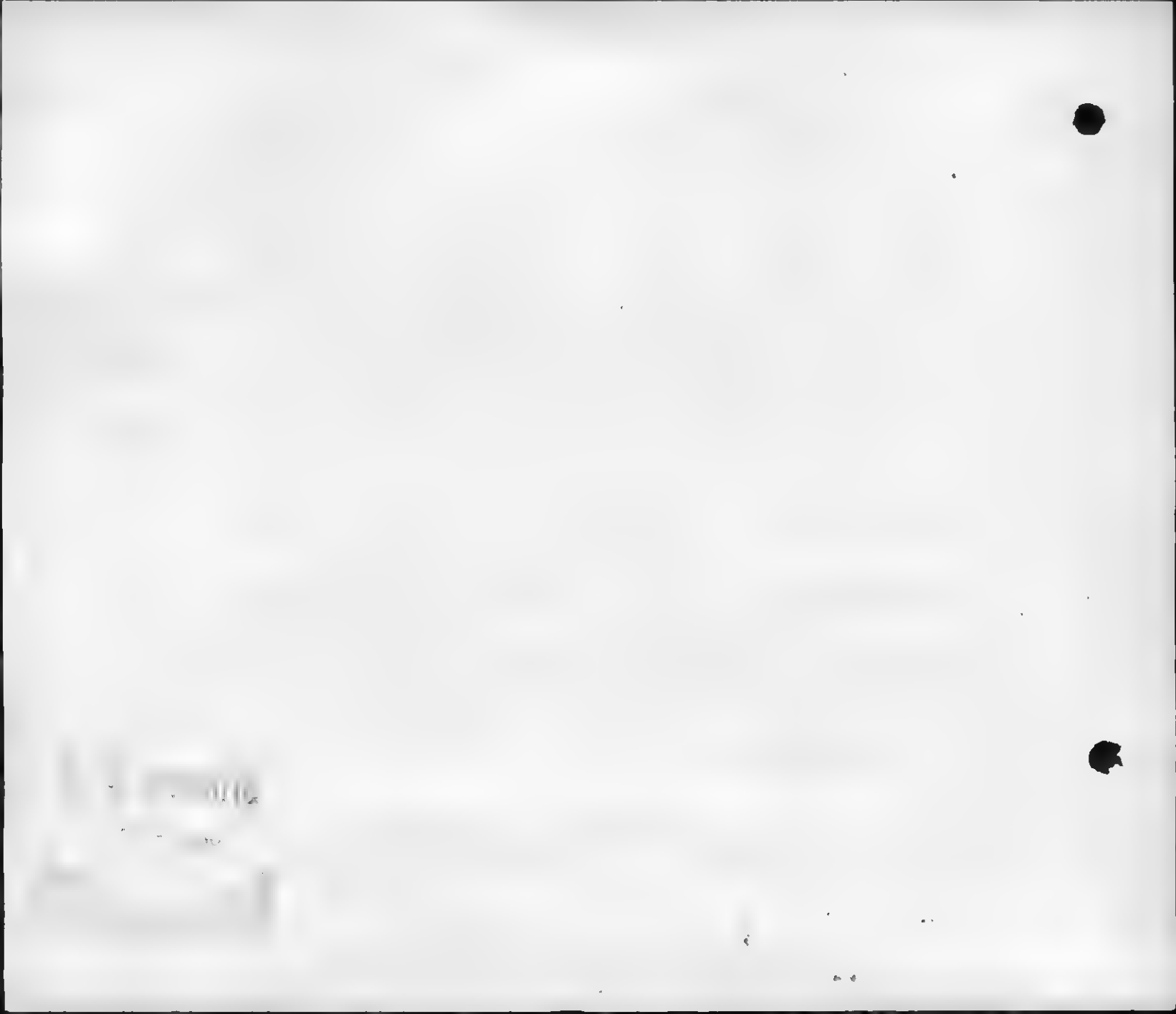
06643

6632

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) Years		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>634 Grant Place</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ANNETTE JESTINE DETERDING</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>JULY 28</u> <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>December 29, 1877</u>		9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Samuel Hunter</u>				14. MOTHER'S MAIDEN NAME: <u>Ann Robinson Bell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>No</u> <u>Non</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Samuel F. Deterding, Frederick, Maryland</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
42.5.0 IMMEDIATE CAUSE						<u>24 hours</u>	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(A) <u>Gangrene Small Bowel</u>							
(B) <u>Arterio-sclerotic and hypertensive</u>							
(C) <u>Heart disease</u>						<u>30+ years.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Infarcts of lungs &amp; kidneys</u>						<u>5-6 weeks.</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1946</u> to <u>28 July, 1955</u> , that I last saw the deceased alive on <u>28 July, 1955</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Conley, Jr.</u>		M.D. <u>Frederick, Maryland</u>		DATE SIGNED <u>7/28/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>29 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Hetch</u>		24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS	



6632

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Frederick</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Frederick</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>11</u> <u>Town</u> <u>Frederick</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR</u> <u>Town</u> <u>Frederick</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>19</u> <u>Frederick Memorial Hospital</u>			STREET ADDRESS (If rural give location) <u>522 Klineharts Alley</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) ERNEST WEEDON DIXON			4. DATE (Month) (Day) (Year) OF DEATH: <u>July 6,</u> 19 <u>55</u>		
5. SEX: Male			6. COLOR OR RACE: Colored		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>			8. DATE OF BIRTH: <u>March 22, 1897</u>		
9. AGE last birthday <u>58</u> yrs			10. IF UNDER 1 YEAR Months Days		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Unknown</u>		
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME: <u>William Hixon</u>			14. MOTHER'S MAIDEN NAME: <u>Dora Harmon</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give year or dates of service) <u>No</u>			16. SOCIAL SECURITY NO: <u>217-10-9268</u>		
17. INFORMANT & ADDRESS: <u>522 Klineharts Alley, Mrs. Bertie Goines, Frederick, Maryland</u>					
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE <u>442X</u>					
ANTECEDENT CAUSE (S)					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.					
(A) <u>Hypertensive cardiovascular disease</u>					<u>6 mos.</u>
(B) DUE TO					
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION.		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 2, 1955</u> , to <u>July 6, 1955</u> that I last saw the deceased alive on <u>July 6, 1955</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>Dr. B. Martin</u>		M. D. <u>Frederick, Maryland</u>		DATE SIGNED <u>7/8/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 9, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>					
DATE REC'D BY LOCAL REGISTRAR <u>8 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Hask</u>		24. FUNERAL DIRECTOR ADDRESS <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>	

MARGIN RESERVED FOR BINDING

U. S. DEPARTMENT OF AGRICULTURE

1955

1955



6634

## MARYLAND STATE DEPARTMENT OF HEALTH

06645

## CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH - COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>173 West Patrick Street</u>		STREET ADDRESS (If rural, give location) <u>173 West Patrick Street</u>	
3. NAME OF DECEASED (First) <u>EVA</u> (Middle) <u>MAY</u> (Last) <u>DIXON</u>	4. DATE OF DEATH (Month) <u>July</u> (Day) <u>15</u> (Year) <u>1955</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10 June 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>attress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	9. AGE last birthday <u>44</u> yrs. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Shipe</u>		14. MOTHER'S MAIDEN NAME <u>Flora Cole</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Russell L. Shipe, Brunswick, Maryland</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
<u>781X</u> Immediate cause (a) <u>Gun Shot Wound Left Chest</u>		<u>5 Minutes ?</u>
Antecedent cause(s) (b) <u>(38 CAL. Revolver)</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	(CITY OR TOWN) <u>Frederick</u> (COUNTY) <u>Frederick</u> (STATE) <u>Maryland</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7/15/55 8:30 PM 2m</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Homicide</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

SIGNATURE M. D. Deputy

(Degree or title)

ADDRESS

DATE SIGNED

M. D. Deputy Medical Examiner, Frederick, Maryland

19 July 1955

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>20 July 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>	LOCATION (City, town, or county) <u>Knoxville, Maryland</u>	(State) <u>  </u>
DATE REC'D BY LOCAL REG. <u>19 July 1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth Heck</u>	24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>	ADDRESS <u>  </u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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8. 1000000

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6635

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>1 mo.</u>		<del>OR</del> outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Three Pines Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Military Road</u> 1			
3. NAME OF DECEASED (Type or Print) <u>EFFIE CONOVER</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 4 1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>		8. DATE OF BIRTH: <u>July 16, 1865</u>	
				9. AGE last birthday <u>89</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>		11. BIRTHPLACE (State or foreign country): <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>Nathan S. Conover</u>				14. MOTHER'S MAIDEN NAME: <u>Matilda Hunt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>			
				17. INFORMANT & ADDRESS: <u>Mrs. Frank C. Nicodemus, Walkersville, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hypertensive Arteriosclerotic Heart Disease</u>						5 yrs	
ANTECEDENT CAUSE (B) <u>-</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>-</u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>1) generalized arteriosclerosis 2) fracture of hip (pneumia)</u>						1) 10 yrs 2) 2 1/2 mos.	
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 14, 1954</u> to <u>July 4, 1955</u> , that I last saw the deceased alive on <u>June 27, 1955</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>B. J. Plumb, Jr.</u>		M.D. <u>Walkersville, Md.</u>		DATE SIGNED <u>July 5, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/7/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Pastor Church yard</u>		LOCATION (City, town, or county) <u>Harrisburg, Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>		24. FUNERAL DIRECTOR <u>J.C. Boston, Walkersville, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUL 7 1955

6668

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

COUNTY Frederick

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

X ~~TOWN~~ Near FrederickLENGTH OF STAY  
(in this place)  
25 yearsHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Emergency Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY Frederick

CITY (If outside corporate limits, write RURAL and give nearest town)

X ~~TOWN~~ Route 5 - Nr. Frederick

STREET ADDRESS (If rural give location)

Gambrill Park Road

3. NAME OF  
DECEASED:

(First)

(Middle)

(Last)

NELLIE

M.

ESTABROOK

4. DATE  
OF  
DEATH:

(Month)

(Day)

(Year)

July 14 19 55

## 5. SEX:

6. COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

Female

White

Widowed

1858

97

Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of  
work done during most of working life,  
even if retired):

Housewife

10b. KIND OF BUSINESS OR  
INDUSTRY:

Own Home

## 11. BIRTHPLACE (State or foreign country):

Iowa

12. CITIZEN OF WHAT  
COUNTRY?

USA

## 13. FATHER'S NAME:

George Melling

## 14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

No

## 16. SOCIAL SECURITY No.:

None

## 17. INFORMANT &amp; ADDRESS:

Mrs. Nellie M. Winchester - Frederick, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0  
Immediate cause

(a)

DUE TO

Arterio-sclerotic heart dis. w/

## Antecedent causes (s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.

(b)

DUE TO

Auricular Fibrillation and  
Congestive failure

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

Malignancy left breast

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

Interval Between  
Onset And Death

?

?

## 20. AUTOPSY ?

Yes ☐ No ☐21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY m.

## INJURY OCCURRED

While at

Not While

Work ☐At Work ☐

## HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 30 Apr. 19 53, to 11 July, 19 55, that I last saw the deceased

alive on 8 July, 19 55, and that death occurred at 2:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Charles H. Conley

M.D. Frederick, Md

15 July 19 55

23. BURIAL CREMATION,  
RECEIVED

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

DATE REC'D BY LOCAL  
REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

Burial

July 16, 1955

Mount Olivet Cemetery

Frederick,

Maryland

15 July 1955

Elizabeth S. Heck

C. E. Cline &amp; Son - 8 East Patrick Street -

Frederick, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1-28

6636

07732

1. PLACE OF DEATH- COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MD</b> COUNTY <b>FREDERICK</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>NEW MARKET</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>FREDERICK MEMORIAL HOSPITAL</b>		STREET ADDRESS (If rural, give location) <b>1</b>	
3. NAME OF DECEASED (First) (Middle) (Last) <b>ELIZABETH CARSON FALCOWER</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>JULY 11 1955</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>FEB 22 1914</b> 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>
13. FATHER'S NAME <b>MICHAEL COUGHLIN</b>		14. MOTHER'S MAIDEN NAME <b>MARY NEWTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY No. <b>—</b>	
17. INFORMANT AND ADDRESS <b>W.E. FALCOWER NEW MARKET MD</b>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <b>puerperal edema</b>		3 days	
Antecedent cause(s) (b) <b>puerperal edema</b>		5 days	
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>—</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <b>SUICIDE</b>		PLACE (Home, farm, factory, street, etc.) (CITY OR TOWN) (COUNTY) (STATE) <b>INJURY</b>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 7, 1955</b> to <b>July 11, 1955</b> , that I last saw the deceased alive on <b>July 11, 1955</b> , and that death occurred at <b>1:30 P.M.</b> m., from the causes and on the date stated above.			
SIGNATURE <b>W.E. Falcower</b>		DATE SIGNED <b>July 13 1955</b>	
23. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		DATE THEREOF <b>JULY 14 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>MT OLIVET CEMETARY</b>		LOCATION (City, town, or county) (State) <b>FREDERICK MD</b>	
DATE REC'D BY LOCAL REG. <b>July 13 1955</b>		24. FUNERAL DIRECTOR <b>W.E. Falcower</b>	
REGISTRAR'S SIGNATURE <b>W.E. Falcower</b>		ADDRESS <b>NEW MARKET MD</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The subject age is especially important. Physicians: please write the causes of death clearly and legibly.

BURKAT V. S.

195

195

195



## CERTIFICATE OF DEATH

Reg. Dist. No. 141

6653

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Frederick</b>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Brunswick</b>	LENGTH OF STAY (in this place) <b>70 years</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Brunswick</b>	(If rural, give location) <b>309 East Potomac</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>309 East Potomac</b>		STREET ADDRESS <b>309 East Potomac</b>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <b>Annie</b>	(Middle) <b>Margaret</b>	(Last) <b>Flynn</b>	(Month) <b>7</b> (Day) <b>2</b> (Year) <b>19 55</b>
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH: <b>2-19-1872</b>
9. AGE last birthday: <b>83</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		11b. KIND OF BUSINESS OR INDUSTRY: <b>Home</b>	
12. BIRTHPLACE (State or foreign country): <b>West Virginia</b>		13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. FATHER'S NAME: <b>Lloyd Harper</b>		15. MOTHER'S MAIDEN NAME: <b>Virginia Forney</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		17. SOCIAL SECURITY No.: <b>-</b>	
18. INFORMANT & ADDRESS: <b>E.H.Flynn, Brunswick, Maryland</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
450.0 Immediate cause (a) <b>Chronic bronchitis</b>		<b>7 yrs</b>
DUE TO		
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		
(c) <b>Chronic</b>		

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <b>4/26/54</b> to <b>7/2/55</b> , that I last saw the deceased alive on <b>7/2</b> 19 <b>55</b> , and that death occurred at <b>6 PM</b> from the causes and on the date stated above.	
SIGNATURE <b>[Signature]</b>	(DECEASED OR TITLE) ADDRESS <b>[Signature]</b>
23. BURIAL, CREMATION REMOVAL (Specify): <b>Burial</b>	DATE THEREOF <b>7-5-1955</b>
NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>	LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>
DATE REC'D BY LOCAL REG <b>July 4-55</b>	REGISTRAR'S SIGNATURE <b>Kathryn N. Brown</b>
24. FUNERAL DIRECTOR <b>C.H. Peete and Bro. Brunswick, Md.</b>	

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CHINESE

1911

1911

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6667  
CERTIFICATE OF DEATH

06649

Reg. Dist. No. 1-4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Emmitsburg, Md. Rural</b>		<b>12 yrs.</b>		OR TOWN <b>Emmitsburg, Md. Rural</b> Y			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				/			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <b>Viola May Fury</b>				OF DEATH: <b>7 31 1955</b>			
5. SEX.	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>Female</b>	<b>White</b>	<b>Married</b>	<b>5/25/76</b>	<b>79</b> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life)				11. BIRTHPLACE (State or foreign country):			
<b>Housewife Beautician</b>				<b>Frederick County Md.</b>			
10B. KIND OF BUSINESS OR INDUSTRY:				12. CITIZEN OF WHAT COUNTRY?			
				<b>Citizen USA</b>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME			
<b>David Reightler</b>				<b>Tobiatha Floegle</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<b>No</b>				<b>216-01-6386</b>			
17. INFORMANT & ADDRESS:							
<b>Robert H. Fury Emmitsburg, Md. RFD</b>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <b>myocardial failure</b>						<b>8 hrs.</b>	
ANTECEDENT CAUSE (B) <b>chronic myocarditis</b>						<b>?</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>Arteriosclerosis</b>						<b>?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Bronchial asthma</b>						<b>?</b>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<b>7/31/55</b>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Mar. 2, 1948</b> to <b>July 31, 1955</b> that I last saw the deceased alive on <b>July 31, 1955</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>M. J. [Signature]</b>		M. D. <b>Thurmont Md.</b>		DATE SIGNED <b>Aug. 1, 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>8/3/55</b>		<b>U.B. Cemetery</b>		<b>Thurmont, Md. Frederick, Co</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
				<b>M.L. Creager and Son</b>		<b>Thurmont, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

19

19

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06650

6668

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Balto. City</b>
CITY (If outside corporate limits, write RURAL OR TOWN <b>Cullen</b> )	LENGTH OF STAY (In this place) <b>708 days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hospital</b>		STREET ADDRESS (If rural give location) <b>1329 Linden Avenue</b>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH:	
<b>Richard L. Goodrich</b>		<b>July 2 19 55</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>married</b>	8. DATE OF BIRTH: <b>Dec. 8, 1908</b>
9. AGE last birthday <b>46</b> yrs.		10. UNDER 1 YEAR: Months	11. UNDER 24 HRS. Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>HousePainter</b>	
11. BIRTHPLACE (State or foreign country): <b>Bath, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME: <b>Lionel Goodrich</b>		14. MOTHER'S MAIDEN NAME: <b>Harriet Story</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>Yes W. W. I.</b>		16. SOCIAL SECURITY NO. <b>073-16-6037</b>	
17. INFORMANT & ADDRESS: <b>Mrs. Mae J. Goodrich, Wife, Same address.</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<b>2 1/2 years.</b>	
IMMEDIATE CAUSE (A) <b>Pulmonary Tuberculosis</b>			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 24, 1953</b> , to <b>July 2, 19 55</b> that I last saw the deceased alive on <b>July 2, 19 55</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>[Signature]</b>		M.D. <b>Cullen, Maryland</b> DATE SIGNED <b>July 5, 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Delivered</b>		DATE THEREOF <b>7-14-55</b>	
NAME OF CEMETERY OR CREMATORY <b>Dept. of Anatomy, U. of M.</b>		LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>7/5/55</b>		24. FUNERAL DIRECTOR ADDRESS	

THE JOURNAL OF

19

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6657 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06651									
CERTIFICATE OF DEATH									
Reg. Dist. No. 141									
1. PLACE OF DEATH: Frederick					2. USUAL RESIDENCE (HOME) OF DECEASED: Maryland Frederick				
COUNTY		MARYLAND			STATE		COUNTY		
CITY (If outside corporate limits, write RURAL and give nearest town) 35 TOWN Brunswick				LENGTH OF STAY (in this place) 50 yrs.					
HOSPITAL OR INSTITUTION OR STREET ADDRESS 515 Brunswick Street					STREET ADDRESS (If rural, give location) 515 Brunswick Street				
3. NAME OF DECEASED: (First) (Middle) (Last) Earl Calvin Grams									
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, Married		8. DATE OF BIRTH: 8-31-1886-1885		9. AGE last birthday: 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if not stated elsewhere) Retired Conductor		10b. KIND OF BUSINESS OR INDUSTRY: Band O.R.R.Co.		11. BIRTHPLACE (State or foreign country): Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Thomas E. Grams					14. MOTHER'S MAIDEN NAME: Addie Haines				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Mrs. Florence May Grams, Brunswick, Md.			
18. MEDICAL CERTIFICATION									
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:									
420.1 Immediate cause (a) DUE TO									
Antecedent cause(s) (b) DUE TO									
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)									
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION:					19b. MAJOR FINDINGS OF OPERATION:				
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			(CITY OR TOWN)		(COUNTY)		(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from 8/18/55 to 7/14/55, that I last saw the deceased alive on 7/14/55 and that death occurred at 7:00 p.m., from the causes and on the date stated above. SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED 1/6/56									
23. BURIAL, CREMATION (Specify): Burial		DATE THEREOF 7-7-1955		NAME OF CEMETERY OR CREMATORY Locust Valley			LOCATION (City, town, or county) (State) Rural Burkittsville, Md.		
DATE REC'D BY LOCAL REG. July 6-55		REGISTRAR'S SIGNATURE Kathryn A. Brown			24. FUNERAL DIRECTOR C.H. Feete and Bro. Brunswick, Md.				

THE UNIVERSITY

LIBRARY

1950



6637

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) 11 Frederick		LENGTH OF STAY (in this place) 2 Weeks		CITY (If outside corporate limits, write RURAL OR TOWN) Thurmont-Rural RD#1		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital				STREET ADDRESS (If rural give location) Lewistown			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
(Type or Print) LAVINA		KATHERINE		GREEN		July 17, 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
Female	White	Married	7 Sept 1900	54 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
House-work		Own Home		Maryland		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Edward Powell				Susan Holdcraft			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
4 No		None		George W. Green, RD#1, Thurmont, Maryland			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
154X Immediate cause				13 days			
(a) Intestinal Obstruction							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.				3 1/2 yrs.			
(b) Cancerous of Recto. sigmoid							
(c) Exploratory Operation - Reaction to air. ileum				4 days.			
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY ?			
July 17, 1955		Exploratory - Recurrence of carcinoma & obstruction of ileum		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
				Thurmont - 2 Bldg.		Frederick Md.	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
g		m.					
22. I hereby certify that I attended the deceased from July 4, 1955, to July 17, 1955, that I last saw the deceased alive on July 17, 1955, and that death occurred at 3:55 P.M., from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
Frank W. Houghton		M.D.		Frederick, Md.		July 17 - 1955	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		20 July 1955		Mount Olivet Cemetery		Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
19 July 1955		Elizabeth B. Hark		M. R. Etchison & Son, Frederick, Maryland			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. GOVERNMENT

1955

12/1/55

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06653

C663

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Frederick</u> MARYLAND <small>(If outside corporate limits, write RURAL and give nearest town)</small> <u>Lander</u> HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>Glenmerrie Nursing Home</u>			STATE <u>Maryland</u> COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Frederick</u> STREET ADDRESS (If rural give location) <u>501 Lee Place</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>NELLIE</u> <u>BETORIS</u> <u>GREEN</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>July 2,</u> <u>1955</u>		
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>	7. <del>SINGLE, MARRIED, WIDOWED, DIVORCED.</del> (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>11 June 1880</u>	
9. AGE last birthday: <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>House-work</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Andrew Haines</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>501 Lee Place, Mrs. Cecil D. Clay, Frederick, Maryland</u>	
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) <u>Malnutrition - Numerous</u>					} 4 mo
ANTECEDENT CAUSE (B) <u>infected Pressure ulcers</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Cerebral Hemorrhage</u>					2 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Phlebitis Left thigh</u>					1 mo
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec</u> , 1954 to <u>7/2</u> , 1955 that I last saw the deceased alive on <u>6/30</u> , 1955 and that death occurred at <u>6:40A</u> M, from the causes and on the date stated above. SIGNATURE <u>C. D. Brice</u> M. D. <u>Jefferson</u> ADDRESS <u>Maryland</u> DATE SIGNED <u>2 July 1955</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5 July 1955</u>		NAME OF CEMETERY OR CREMATION LOCATION (City, town, or county) (State) <u>Utica Lutheran Cemetery Frederick County Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>		24. FUNERAL DIRECTOR ADDRESS <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>	

100-100000

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6670

## CERTIFICATE OF DEATH

Reg. Dist. No. 140

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> <u>Le Gore</u>		<u>Life</u>		<u>Le Gore</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>—</u>				<u>/</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH: <u>July</u> <u>22</u> <u>1955</u>			
<u>BLANCHE CORILLA GRIMES</u>							
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed Mar. 12, 1892</u>		8. DATE OF BIRTH: <u>63</u> yrs. <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>General</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Rubber Co. + Canning</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Jacob Potts</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Louisa</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO: <u>212-14-6849</u>			
17. INFORMANT & ADDRESS: <u>Mr. Sheridan L. Grimes, Le Gore, md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1</u> <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE (B) <u>260.81</u> <u>Diabetes</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 15, 1955</u> to <u>July 22, 1955</u> that I last saw the deceased alive on <u>July 15, 1955</u> and that death occurred at <u>Le Gore, md.</u> from the causes and on the date stated above.							
SIGNATURE: <u>J. D. Missin</u>		M. D. <u>J. D. Missin</u>		DATE SIGNED: <u>July 24, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>7/24/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Oak Hill</u>		LOCATION (City, town, or county) (State): <u>Le Gore md.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>7/24/55</u>		REGISTRAR'S SIGNATURE: <u>L. C. Powell</u>		24. FUNERAL DIRECTOR: <u>J. C. Bastin, Walkersville, md.</u>		ADDRESS: <u>—</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED A. B.

JUL 10 1955

100-100000

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6671

## CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH COUNTY <b>Frederick</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Creagerstown rural</b> LENGTH OF STAY (in this place) <b>12 yrs.</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Maryland</b> COUNTY <b>Frederick</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Creagerstown Rural</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>		STREET ADDRESS (If rural give location) <b>1</b>	
3. NAME OF DECEASED: (Type or Print) (First) <b>Ralph</b> (Middle) <b>Harrison</b> (Last) <b>Grinder</b>		4. DATE (Month) (Day) (Year) OF DEATH <b>July 23 1955</b>	
5. SEX: <b>male</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH: <b>February 27 1888</b>
9. AGE last birthday: <b>67 yrs.</b>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if not now doing it) <b>Adjudicator</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Veterans Amd.</b>	
11. BIRTHPLACE (State or foreign country): <b>Creagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>John Wesley Grinder</b>		14. MOTHER'S MAIDEN NAME: <b>Eleanor Baker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) <b>Yes</b> (If Yes, give war or dates of service) <b>World War I</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT'S ADDRESS: <b>Mrs. Esther Grinder Creagerstown</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Carcinomatosis</b>			<b>4 mos.</b>
ANTECEDENT CAUSE (B) <b>Carcinoma of right lung</b>			<b>8 mos.</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>Chronic myocarditis</b>			<b>5 yrs.</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <b>Jan. 31, 1955</b>		19B. MAJOR FINDINGS OF OPERATION: <b>Carcinoma of lower lobe of right lung</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan. 5, 1955</b> to <b>July 23, 1955</b> , that I last saw the deceased alive on <b>July 22, 1955</b> , and that death occurred at <b>3:45 AM</b> , from the causes and on the date stated above. SIGNATURE <b>M. Franklin Birch</b> M. D. <b>Thurmond</b> DATE SIGNED <b>July 23, 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>July 25 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Creagerstown Cem.</b>		LOCATION (City, town, or county) (State) <b>Creagerstown Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>July 25 1955</b>		REGISTRAR'S SIGNATURE <b>Blanche S. Eyles</b>	
24. FUNERAL DIRECTOR <b>Wm. E. Eager</b>		ADDRESS <b>San Thurmond Md.</b>	

BUNNELL N. R.

1900



6672

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Baltimore City</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Cullen</b>		LENGTH OF STAY (in this place) <b>13 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>		<b>3664</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hospital</b>				STREET ADDRESS (If rural give location) <b>9 West Lee Street,</b>		<b>V</b>	
3. NAME OF DECEASED: (Type or Print)		(First) <b>Emma</b>		(Middle) <b>May</b>		(Last) <b>Harkson</b>	
4. DATE OF DEATH:		(Month) <b>July</b>		(Day) <b>21</b>		(Year) <b>1955</b>	
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Divorced</b>		8. DATE OF BIRTH: <b>5/27/1899</b>	
9. AGE last birthday <b>56</b> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <b>Housewife</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Frederick Eckarius</b>				14. MOTHER'S MAIDEN NAME: <b>Anna ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT & ADDRESS: <b>Emma May Harkson, 9 W. Lee St., Baltimore, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Metastatic carcinoma of liver.</b>						<b>Unknown.</b>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <b>Carcinoma of head of Pancreas.</b>						<b>Unknown.</b>	
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Pulmonary Tuberculosis</b>						<b>4 months.</b>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 8</b> , 19 <b>55</b> to <b>July 21</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>July 21</b> , 19 <b>55</b> , and that death occurred at <b>10:25 M.</b> from the causes and on the date stated above.							
SIGNATURE <b>[Signature]</b>		A.M. ADDRESS <b>Cullen, Md.</b>		DATE SIGNED <b>July 21, 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>7-25-55</b>		NAME OF CEMETERY OR CREMATORY <b>Lawson</b>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <b>7/21/55</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR <b>[Signature]</b>		ADDRESS <b>[Address]</b>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

6638

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>130 West Fourth Street</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>ROSA</u>		<u>CLARA</u>		<u>HAUSLER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 25, 1955</u>	
5. SEX.	6. COLOR OR RACE:	7. <del>SINGLE</del> MARRIED, <del>WIDOWED</del> <del>DIVORCED</del> (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>September 24, 1888</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>Home</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Anthony F. Wickless</u>				<u>Laura Joy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>		<u>No</u>		<u>None</u>		<u>Mrs. Richard E. Brown, Frederick R.F.D.#5, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						<u>24 hours</u>	
ANTECEDENT CAUSE (B) <u>Hypertensive heart disease</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/24, 1955</u> , to <u>7/25, 1955</u> , that I last saw the deceased alive on <u>7/25, 1955</u> , and that death occurred at <u>3:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James B. Thomson</u>				ADDRESS <u>M.D. Frederick, Maryland</u>		DATE SIGNED <u>7/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 28, 1955</u>		<u>St. Johns Cemetery</u>		<u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>26 July 1955</u>		<u>Elizabeth L. Heck</u>		<u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

JUL 27

RECEIVED

6639

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Fredrick</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Fredrick</u>
CITY (If outside corporate limits, write RURAL or give nearest town) <u>11 Fredrick</u>	LENGTH OF STAY (in this place) <u>2 da</u>	If outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>69 Fredrick Mem. Hospital</u>	STREET ADDRESS (If rural give location) <u>1</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <u>William</u>	(Middle) <u>R</u>	(Last) <u>Henshaw</u>	<u>July 8 19 53</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>March 5-1869</u>
9. AGE last birthday: <u>86</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Miner</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Coking steel</u>	
11. BIRTHPLACE (State or foreign country): <u>Thurmont</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John J. Henshaw</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Rouzer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service: <u>no</u>		16. SOCIAL SECURITY NO: <u>no</u>	
17. INFORMANT & ADDRESS: <u>Miss Grace Henshaw Thurmont</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Intestinal obstruction</u>			<u>2 days</u>
ANTECEDENT CAUSE (B) <u>Infection of terminal ileum</u>			<u>3 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Anteromedullary Heart Disease with pulmonary edema</u>			<u>? yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 6, 1953</u> , to <u>July 8, 1953</u> , that I last saw the deceased alive on <u>July 8, 1953</u> , and that death occurred at <u>6 A</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Henry V. Chase</u>		ADDRESS <u>M. D. 4 E. Church St</u>	
DATE SIGNED <u>7/8/53</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF <u>July 10-1953</u>	
NAME OF CEMETERY OR CREMATORY <u>St. B. Cem</u>		LOCATION (City, town, or county) (State) <u>Thurmont Fred Co Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9 July 1953</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>	
FEDERAL DIRECTOR <u>M. C. Cragg</u>		ADDRESS <u>San Thurmont Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

06659

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

6640

1. PLACE OF DEATH- COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital		STREET ADDRESS (If rural, give location) 6 West Second Street	
3. NAME OF DECEASED (Type or Print)	(First) HENRY (Middle) WILLIAM (Last) HERMAN	4. DATE OF DEATH (Month) July (Day) 14 (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. STATUS, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 23, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sports Editor		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	9. AGE last birthday 59 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John G. Herman		14. MOTHER'S MAIDEN NAME Ella May Anthony	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY No. 527-05-4120	
17. INFORMANT AND ADDRESS Mrs. Agnes S. Herman, Frederick, Md.		18. W. Second St.,	

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
4-20-1 Immediate cause (a) CORONARY OCCLUSION		1 Hour
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☒. Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, or other disposition (Specify) Burial	DATE THEREOF July 17, 1955	NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	LOCATION (City, town, or county) Frederick, Maryland
DATE REC'D BY LOCAL REG. 16 July 1955	REGISTRAR'S SIGNATURE Elizabeth G. Heck	24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1000

1000



6673

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Cullen		1 day		OR TOWN Frostburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital				STREET ADDRESS (If rural give location) Route #1, Box 86			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
James T. Hitchins				July 15, 1955			
5. SEX		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):		8. DATE OF BIRTH:	
Male		White		Married.		March 12, 1885	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
70 yrs.		Coal Miner		Maryland		U. S. A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
James Hitchins				Mary A. Stevens			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
No				213-05-7123		James T. Hitchins, Rt. #1, Box 86, Frostburg, Md.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) Pulmonary Tuberculosis			
ANTECEDENT CAUSE (B)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
C							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 14, 1955, to July 15, 1955, that I last saw the deceased alive on July 15, 1955, and that death occurred at 8:00 M. from the causes and on the date stated above.							
SIGNATURE				A.M. ADDRESS		DATE SIGNED	
J. Cullen				M. D. Cullen, Maryland		July 18, 1955.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 18, 1955		Frostburg Memorial Park,		Frostburg, Maryland.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7/18/55		J. Cullen		M. L. Creager & Son, Thurmont,		Maryland	

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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6674

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Town Lander</u>		LENGTH OF STAY (in this place) <u>Months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glen Merrie Nursing Home</u>				STREET ADDRESS (If rural give location) <u>207 East Second Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES PHILIP HITESHEW Sr.</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 10, 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>February 14, 1885</u>	
9. AGE last birthday <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) <u>Retired Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Automobiles</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>P. Merhl Hiteshe</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Keller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-10-5757</u>		17. INFORMANT & ADDRESS: <u>255 Washington Street</u> <u>C. Philip Hiteshe, Jr., Frederick, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.0</u>							
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(A) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>with acute congestive failure</u>	
						(B) DUE TO	
						(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Myocardial infarction</u>						(A) <u>Myocardial infarction</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/5/54</u> , 19 <u>54</u> , to <u>7/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/8</u> , 19 <u>55</u> , and that death occurred at <u>12:30M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Henry V. Chase</u>				M. D. <u>Frederick, Maryland</u>		DATE SIGNED <u>7/11/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Hebl</u>		24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

1 - 1955

6675

## CERTIFICATE OF DEATH

Reg. Dist. No. 134

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN Emmitsburg,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		207 West Main		STREET ADDRESS (If rural give location)		207 West Main	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Joseph Robert Hoke				July 5, 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: Sept, 7, 1886	
9. AGE last birthday: 68 yrs.		10. MONTHS: 6		11. DAYS: 5		12. HOURS: 1955	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Caretaker				10b. KIND OF BUSINESS OR INDUSTRY: Janitor		11. BIRTHPLACE (State or foreign country): Emmitsburg, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME: Michael Hoke			
14. MOTHER'S MAIDEN NAME: Laura Smith				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No			
16. SOCIAL SECURITY No.: 219-30-9956				17. INFORMANT & ADDRESS: Mrs. George Gungell Fairfield, Pa. R.D. # 1			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		2 years	
Immediate cause (a) Carcinoma prostate			
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO			
(c)			

11. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
SUICIDE		(CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 26, 1955, to July 5, 1955, that I last saw the deceased alive on July 5, 1955, and that death occurred at 2:00 PM, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
W. R. Cade, M.D.		Emmitsburg, Md. 7-6-55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
Burial		July 8, 1955	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
St. Josephs Catholic		Emmitsburg, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
July 7-1955		M. F. Shuff	
24. FUNERAL DIRECTOR		ADDRESS	
S. L. Allison		Emmitsburg, Md.	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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## MARYLAND STATE DEPARTMENT OF HEALTH

6641

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH- COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 246 East Third Street		STREET ADDRESS (If rural, give location) 246 East Third Street	
3. NAME OF DECEASED (Type or Print)	(First) EFFIE	(Middle) LUCKETT	(Last) HAUSER HORINE
4. DATE OF DEATH	July 31, 1955		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH 29 Jan 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	9. AGE last birthday 65 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Mahoney		14. MOTHER'S MAIDEN NAME Amanda Ausherman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-20-1233A	
17. INFORMANT AND ADDRESS Willard M. Horine, Frederick, Md.		5 S. Market St.,	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

430.1  
Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING

PLACE (Home, farm, factory, street, office, etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION OR OTHER DISPOSITION (Specify) Burial

DATE THEREOF

3 Aug 1955

NAME OF CEMETERY OR CREMATORY

Lutheran Cemetery

LOCATION (City, town, or county)

Middletown, Maryland

(State)

DATE REC'D BY LOCAL REG.

August 1955

REGISTRAR'S SIGNATURE

Ely...

24. FUNERAL DIRECTOR

M. R. Etchison &amp; Son, Frederick, Md.

ADDRESS

MARGIN RESERVE FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6675

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06664

## CERTIFICATE OF DEATH

Reg. Dist. No. 131.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Frederick</i>
<del>OR</del> (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	<del>OR</del> (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <i>Middletown</i>	<i>40 years</i>	OR TOWN <i>Middletown</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	<i>1</i>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <i>William H. Johnson</i>		OF DEATH: <i>7 18 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<i>male</i>	<i>colored</i>	<i>widowed</i>	<i>6-9-1885</i>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<i>70 yrs.</i>		<i>Maryland</i>	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
<i>U.S.</i>		<i>U.S.</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Henry Johnson</i>		<i>Katherine Butler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>no</i>		<i>216-22-9381</i>	
17. INFORMANT & ADDRESS:			
<i>Audrey Cox, Middletown, Md.</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i>		<i>Suddenly</i>	
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>Arterio Sclerosis</i>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<i>U</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) (Min.)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 16, 1955</i> , to <i>July 18, 1955</i> , that I last saw the deceased alive on <i>July 17, 1955</i> , and that death occurred at <i>10:30 P.</i> from the causes and on the date stated above.			
SIGNATURE <i>J E Harp</i>		DATE SIGNED <i>July 19 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>Reformed Cemetery</i>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town or county) (State)	
<i>7-20-1955</i>		<i>Middletown, Md.</i>	
REGISTRAR'S SIGNATURE <i>Elizabeth Y. Heck</i>		24. FUNERAL DIRECTOR ADDRESS	
		<i>Gladhill Co., Middletown, Md.</i>	

THE UNIVERSITY OF

CHICAGO

LIBRARY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6677

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Frederick</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Petersville</b>		<b>30 years</b>		OR TOWN <b>Petersville</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
-				-			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Mabel C. Purce Jones				7 13 1955			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, Married		8. DATE OF BIRTH:	
Female		White				I-10-1877	
						78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even Housewife)				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Housewife				Home		Virginia	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Alfred Newton Purce				Mary Bell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
No				-		Alfred Jones, Falls Church, Va.	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
321X Immediate cause (a) Hypostatic pneumonia - Dementia							
Antecedent cause(s) (b) Cerebral hemorrhage & c.s.							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Advanced Cerebral Arteriosclerosis							
II. OTHER SIGNIFICANT CONDITIONS:							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at Not while work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from....., 1950, to..... 7/13 1955, that I last saw the deceased alive on..... 7/13, 1955, and that death occurred at..... 4:00 p.m., from the causes and on the date stated above.							
SIGNATURE		(DEGREE OR TITLE)		ADDRESS		DATE SIGNED	
C. J. Barber		M.D.		Jefferson Md		7/14/55	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-15-55		Park Heights		Brunswick, Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
July 15-55		Kathryn N. Brown		C.H. Feete and Bro. Brunswick, Md			

W. W. RICHARDS

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06666

6678

## CERTIFICATE OF DEATH

Reg. Dist. No. 140

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Rural, Walkersville</u>		<u>2 yrs.</u>		<u>Ladysburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>ETTA</u>		<u>MAE</u>		<u>KLINE</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Sept. 19, 1889</u>	
						9. AGE last birthday: <u>65</u> yrs.	
						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>	
						11. BIRTHPLACE (State or foreign country): <u>md.</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Edward L. Fogle</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Virginia Kaefer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
				17. INFORMANT & ADDRESS: <u>Mrs. Fern Staley, Walkersville, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <u>Diabetes, Mel.</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-16, 1955</u> , to <u>7-16, 1955</u> , that I last saw the deceased alive on <u>7-15, 1955</u> and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. H. Legg</u>		ADDRESS <u>Verney Bridge</u>		DATE SIGNED <u>7-18-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rocky Hill Lutheran Cem.</u>		LOCATION (City, town, or county) (State) <u>Md. Woodsboro</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/18/55</u>		REGISTRAR'S SIGNATURE <u>L. B. Powell</u>		24. FUNERAL DIRECTOR <u>T. C. Barton, Walkersville, Md.</u>		ADDRESS	

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MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

07742

Reg. Dist. No. 144

1. PLACE OF DEATH COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont rural</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont Rural</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Thurmont, rural, give location</b>		STREET ADDRESS <b>Thurmont, rural, give location</b>	
3. NAME OF DECEASED (Type or Print) <b>JAMES WILLIAM KNOTT</b>		4. DATE OF DEATH <b>July 29 1955</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>March 24, 1913</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Guy Knott Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Eliza G. Sweeney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		17. INFORMANT AND ADDRESS <b>Guy Knott Jr., Thurmont, Md. R.D. I</b>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <b>10 Min</b>
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>Immediate cause (a) Incendication, asphyxiation</b> <b>Antecedent cause(s) (b) House caught on fire</b> <b>(c) Disease or condition, if any, giving rise to the above cause stating the underlying cause last</b>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <b>7/29/55</b>	19b. MAJOR FINDINGS OF OPERATION <b>None</b>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH TIME (Month) (Day) (Year) (Hour) OF INJURY <b>7/29/55/10:25</b>	PLACE (Home, farm, factory, street, office, etc.) OF INJURY <b>Home</b>	(CITY OR TOWN) <b>Thurmont</b>	(COUNTY) <b>Frederick Co.</b>
INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <b>Incendication</b>	
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <b>R. W. Bace M.D. - Dist. Med. Ex., Frederick</b> DATE SIGNED <b>7/30/55</b>			
23. BURIAL, CREMATION, REINBURSEMENT (Specify) <b>Burial</b>	DATE THEREOF <b>Aug. 1, 1955</b>	NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>	LOCATION (City, town, or county) (State) <b>Thurmont Md.</b>
DATE REC'D BY LOCAL REG. <b>Aug. 1 1955</b>	REGISTRAR'S SIGNATURE <b>Blanche S. Eyles</b>	24. FUNERAL DIRECTOR & Son Thurmont ADDRESS <b>Thurmont</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

U.S. AIR FORCE

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## MARYLAND STATE DEPARTMENT OF HEALTH

6630

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 140

1. PLACE OF DEATH - COUNTY <u>Frederick Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>250 S. Seton St.</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
TOWN <u>Frederick</u>		TOWN <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>280 S. Seton St.</u>	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>Everett</u> (Last) <u>Knox</u>		4. DATE OF DEATH (Month) <u>7</u> (Day) <u>30</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 13, 1932</u>
9. AGE last birthday <u>22</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Knox</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Baumgardner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-30-2930</u>	
17. INFORMANT AND ADDRESS <u>Charles W. Knox</u>		18. ADDRESS <u>280 S. Seton St. Emmitsburg</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Electrocution</u>		<u>3 months</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Frederick</u>	(CITY OR TOWN) <u>Frederick</u> (COUNTY) <u>Frederick</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7/2/55</u> P.m.	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>While working in the mine</u>
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, or thereon and from the evidence obtained by said Autopsy, Inspection, or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>		
SIGNATURE <u>John F. Schuff</u>		DATE SIGNED <u>7/2/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Aug. 2, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Keysville Cemetery</u>
LOCATION (City, town, or county) <u>Emmitsburg, Md.</u>		(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>Aug 1 - 1955</u>	REGISTRAR'S SIGNATURE <u>John F. Schuff</u>	24. FUNERAL DIRECTOR <u>S. L. Allison</u>
ADDRESS <u>Emmitsburg, Md.</u>		

MARGIN RESERVE FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ROBERT V. S.

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6631

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>md.</i>	COUNTY <i>Frederick</i>
<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town) <i>X TOWN Rural Middletown</i>	LENGTH OF STAY (in this place) <i>life</i>	<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town) <i>X TOWN Rural Middletown</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>11</i>		STREET ADDRESS (If rural give location) <i>1</i>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <i>Bruce</i>	(Middle) <i>Sheffer</i>	(Last) <i>Koogle</i>	
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>9-21-1906</i>
9. AGE last birthday: <i>48</i> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>farmlaborer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>farm</i>	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Calvin P. Koogle</i>		14. MOTHER'S MAIDEN NAME: <i>Sally M. Sheffer</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <i>Mrs. Doris Koogle, Middletown, Md.</i>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE		1 day	
(A) <i>Acute Coronary Thrombosis</i>			
ANTECEDENT CAUSE (S)		?	
(B) <i>Coronary Artery disease</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7/26, 1954</i> , to <i>7/28, 1955</i> , that I last saw the deceased alive on <i>April 15, 1955</i> , and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Kenneth C. Nenson</i>		DATE SIGNED <i>7/30/55</i>	
23. BURIAL, CREMATION, REMOVE (SPECIFY) <i>Burial</i>		DATE THEREOF <i>7-31-1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Lutheran Cemetery</i>		LOCATION (City, town, or county) (State) <i>Middletown, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>31 July 1955</i>		REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>	
24. FUNERAL DIRECTOR <i>Gladhill Co.</i>		ADDRESS <i>Middletown, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6632 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06669

## CERTIFICATE OF DEATH

Reg. Dist. No. 139.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY City	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN Cullen		210 days		TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital				STREET ADDRESS (If rural give location) 125 Cheapside Ave., Baltimore, Md.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Mike Kosz				July 14, 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
Male	White	single	Dec. 29, 1884	70 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Mercy Hospital Worker						Austria	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Tom Kosz				Mary Legyer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
No				203-07-6063		Mike Kosz, 125 Cheapside Ave., Balto., Md.	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
334X IMMEDIATE CAUSE (A) Cerebral apoplexy							2 days.
ANTECEDENT CAUSE (B) Generalized arteriosclerosis							Unknown.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 002X (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary Tuberculosis							2 years.
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 16, 19 54, to July 14, 19 55, that I last saw the deceased alive on July 14, 19 55, and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
SIGNATURE				M.D.		DATE SIGNED	
Burial				Cullen, Md.		July 15, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-5-55		Loudon Park		Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7/15/55		[Signature]		Wm. Triskner		Balto., Md.	

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## MARYLAND STATE DEPARTMENT OF HEALTH

06670

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH- COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Mt. Union, Pa.</u> COUNTY <u>Pa.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Near Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>25 X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Grove Lime Plant</u>		STREET ADDRESS (If rural, give location) <u>132 West Halley Street</u>	
3. NAME OF DECEASED (First) <u>CLEMENT</u> (Middle) <u>GEORGE</u> (Last) <u>KROUSE</u>	4. DATE OF DEATH (Month) <u>July</u> (Day) <u>28</u> (Year) <u>1955</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 10, 1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner and Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	9. AGE last birthday <u>44</u> yrs. If under 1 year Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilson S. Krouse</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Geir</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>201-10-9804</u>	
17. INFORMANT AND ADDRESS <u>132 W. Halley Street, Mrs. Gretchen Krouse, Mount Union, Penna.</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>420.1 Coronary occlusion</u> Immediate cause		<u>Immediate</u>
(b) <u>" Heart disease</u> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>Unknown</u>
(c) <u>  </u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>near Frederick, Md.</u> (CITY OR TOWN) <u>Frederick, Md.</u> (COUNTY) <u>Frederick, Md.</u> (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>  </u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>  </u>

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>July 31, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>	LOCATION (City, town, or county) <u>Mount Union, Penna.</u> (State) <u>  </u>
DATE REC'D BY LOCAL REG <u>29 July 1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>	24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>	ADDRESS <u>  </u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick-Rural R.F.D.#2</u> LENGTH OF STAY (in this place) <u>Life</u>				STATE <u>Maryland</u> COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick-Rural R. F. D. #2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Park Mills Rd. (Near Urbana)</u>				STREET ADDRESS (If rural give location) <u>Park Mills Rd. (Near Urbana)</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
(Type or Print)		<u>EFFIE ELLEN LENHART</u>		July 4, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	Widow	February 21, 1879	76 yrs	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Housework</u>				<u>Own Home</u>		<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>James E. White</u>				<u>Mary E. Perrell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>No</u>				<u>None</u>			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
<u>Claude O. Lenhart, Frederick R. F. D. #2, Md.</u>				DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				3420.2			
IMMEDIATE CAUSE (A)				<u>Angina pectoris</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Arterio Sclerosis</u>			
				DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 4, 1955</u> , to <u>July 4, 1955</u> , that I last saw the deceased alive on <u>July 4, 1955</u> , and that death occurred at 6:15 PM, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS <u>Frederick, Maryland</u>			
				DATE SIGNED <u>7/5/1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 7, 1955</u>		<u>Mount Olivet Cemetery</u>		<u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5 July 1955</u>		<u>Elizabeth H. Hack</u>		<u>M. R. Etchison &amp; Son</u>		<u>Frederick, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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## MARYLAND STATE DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH - COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>XXXXXX</u> MD COUNTY <u>Fred.</u>	
CITY (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (if outside corporate limits, write RURAL and give nearest town) <u>Mountaindale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Mem. Hospital</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>SARAH ANN MARSHALL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7 14 1953</u>	
5. SEX <u>Female</u> COLOR OR RACE <u>White</u>		6. DATE OF BIRTH <u>Dec 31, 1875</u> 79 yrs.	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. AGE last birthday <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co MD</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Wm. R. May</u>		14. MOTHER'S MAIDEN NAME <u>Laura V. Ambrose</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause <u>Coronary occlusion</u>			
(b) Antecedent cause(s) <u>42001</u>			
(c) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <u>P.W. Bauer</u> ADDRESS <u>Frederick</u> DATE SIGNED <u>7/14/53</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>July 18, 1955</u> NAME OF CEMETERY OR CREMATORY <u>Lewistown Cem</u> LOCATION (City, town, or county) (State) <u>Lewistown Fredk Co Md</u>	
DATE REC'D BY LOCAL REG. <u>16 July 1955</u> RESTORER'S SIGNATURE <u>Eligible S. Herb</u>		24. FUNERAL DIRECTOR <u>M. L. Creager &amp; Son</u> ADDRESS <u>Thurmont Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Frederick</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	LENGTH OF STAY (in this place) <i>Lifetime</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>354 W. Patrick St.</i>		STREET ADDRESS (If rural give location) <i>354 W. Patrick St.</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>FRANKLIN</i>	(Middle) <i>David</i>	(Last) <i>Milner</i>	(Month) <i>7</i> (Day) <i>4</i> (Year) <i>1955</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. <i>SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</i> <i>married</i>	8. DATE OF BIRTH: <i>5-10-1880</i>
9. AGE last birthday: <i>75</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>Cabinet maker</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Lumber yard</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME: <i>Pierce Miller</i>		14. MOTHER'S MAIDEN NAME: <i>Cora Cramer</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <i>no</i>		16. SOCIAL SECURITY No.: <i>214-10-2416</i>	
17. INFORMANT & ADDRESS: <i>Frederick-Md.</i>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
330X Immediate cause (a) <i>Subarachnoid Hemorrhage</i>		3 hrs.	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>Atherosclerosis</i>		3 1/2 yrs +	
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 4, 1955</i> , to <i>July 4, 1955</i> , that I last saw the deceased alive on <i>July 4, 1955</i> , and that death occurred at <i>5 a/m</i> , from the causes and on the date stated above.			
SIGNATURE <i>Bob Thompson</i>		DATE SIGNED <i>July 5-1955</i>	
23. BURIAL, CREMATION, REBURYAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>7-6-1955</i>	<i>Mt. Olivet Cemetery</i>	<i>Frederick-Md.</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>5 July 1955</i>	<i>Elizabeth G. Heck</i>	<i>C. E. Cline &amp; Son</i>	<i>Frederick-Md.</i>

MARGIN RESERVE FOR BINNING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

06674

Reg. Dist. No. 131

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Waltz  
Winfield.

1. PLACE OF DEATH— COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>MD</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>F.A. 11 N. W. 11</u>		STREET ADDRESS <u>W. 11 N. W. 11</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>W. 11 N. W. 11</u>			
4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>July 4</u>			<u>1955</u>
5. SEX	6. COLOR OR RACE	7. STATUS, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>M</u>	<u>W</u>	<u>WIDOWED</u>	<u>Dec. 28, 1925</u>
9. AGE last birthday	If under 1 year	If under 24 hrs.	
<u>29</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>Manager</u>	<u>Garage</u>	<u>MD</u>	<u>U.S.A.</u>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
<u>W. 11 N. W. 11</u>	<u>W. 11 N. W. 11</u>	<u>No</u>	
16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	18. MEDICAL CERTIFICATION	
<u>W. 11 N. W. 11</u>	<u>W. 11 N. W. 11</u>	1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		INTERVAL BETWEEN ONSET AND DEATH	
823 Immediate cause (a) <u>Crushing injury to chest</u>			
Antecedent cause(s) (b) <u>Heart, coronary</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE		DATE SIGNED	
<u>W. 11 N. W. 11</u>		<u>July 4 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>July 7 1955</u>	<u>Int. Carmel Cemetery</u>	<u>Montgomery Co. Md.</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>7 July 1955</u>	<u>Elizabeth G. H. H.</u>	<u>C. M. W. J. Winfield, Md.</u>	

W. A. AYER & CO.

1850

MADE IN  
U.S.A.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06675

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
<del>CITY</del> (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Braddock Heights</u>		Week		OR TOWN <u>Frederick-Rural # R. F. D. #6.X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vindabona Convalescent Home</u>				STREET ADDRESS (If rural give location) <u>Near Frederick</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>LAURA</u> <u>REBECCA CATHERINE</u> <u>OLAND</u>				OF DEATH: <u>July 20,</u> <u>19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>March 28, 1890</u>	
9. AGE last birthday <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Claude Dutrow</u>				14. MOTHER'S MAIDEN NAME: <u>Ida Beck</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Sharretts E. Oland, Frederick, R.F.D. #6, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of esophagus</u>						<u>6 months</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cachexia</u>						<u>1 week</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 16, 1955</u> , to <u>July 20, 1955</u> , that I last saw the deceased alive on <u>July 19, 1955</u> , and that death occurred at <u>3:05 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H. Lamona Fabray</u>		ADDRESS <u>Frederick, Maryland</u>		DATE SIGNED <u>7/21/1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 22, 1955</u>		<u>Mount Olivet Cemetery</u>		<u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>22 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Herb</u>		24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS	

186

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6645

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>11</u>		If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fred Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>Walkersville</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH:			
(First) <u>John</u> (Middle) <u>Oliver</u> (Last) <u>Poole</u>				DATE (Month) (Day) (Year) <u>July</u> <u>30</u> <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>Dec. 8 1909</u>	
9. AGE last birthday: <u>45</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Glade Valley Bakery</u>		11. BIRTHPLACE (State or foreign country): <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME: <u>John Oliver Poole</u>			
14. MOTHER'S MAIDEN NAME: <u>Ellen Elizabeth Rustman</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>215-10-2533</u>				17. INFORMANT & ADDRESS: <u>Mrs. John O. Poole, Walkersville, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						3 months	
IMMEDIATE CAUSE (A) <u>Acute myeloid leukemia</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>7/30/55</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 1, 1955</u> , to <u>July 30, 1955</u> , that I last saw the deceased alive on <u>July 30, 1955</u> and that death occurred at <u>6A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James E. Howard</u> MD				DATE SIGNED <u>30 July 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Chapel</u>		LOCATION (City, town, or county) (State) <u>Libertytown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-Aug-1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>		24. FUNERAL DIRECTOR <u>S.C. Barton</u>		ADDRESS <u>Walkersville, Md.</u>	

MARGIN RESERVED FOR BINDING

## References

6646

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) 11 <del>Frederick</del> Frederick	LENGTH OF STAY (in this place) Since 6/28/55	CITY (If outside corporate limits, write RURAL and give nearest town) <del>Frederick</del> Mount Airy-Rural	06X-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS 69 Frederick Memorial Hospital		STREET ADDRESS (If rural give location) Near Mount Airy	
3. NAME OF DECEASED: (First) (Middle) (Last) BRICE L. RUNKLES		4. DATE OF DEATH: (Month) (Day) (Year) July 2, 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 7 Jan 1882
9. AGE last birthday: 73 yrs.		10. AGE last birthday: IF UNDER 1 YEAR 1 Year 1955	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farmer		10b. KIND OF BUSINESS OR INDUSTRY: Farm Owner	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Brice Runkles		14. MOTHER'S MAIDEN NAME: Mary Ellen Wilhelm	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No: None	
17. INFORMANT & ADDRESS: Mrs. Zelma N. Runkles, RD., Mount Airy, Md.			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
610X Immediate cause (a) DUE TO Wrenia		1 week
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO Nephrosclerosis		6 months
(c) Prostatism - benign hypertrophy		1 year
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Congestive Heart Failure		1 month
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 29 Dec, 1955, to 2 July, 1955, that I last saw the deceased alive on 2 July, 1955, and that death occurred at 10:50 AM, from the causes and on the date stated above.			
SIGNATURE Thomas E. Shree		DATE SIGNED 4 W 3rd St 7-3-55	
23. BURIAL, CREMATION, (Specify) Burial		DATE THEREOF 5 July 1955	
NAME OF CEMETERY OR CREMATORY Prospect Cemetery		LOCATION (City, town, or county) (State) Frederick County Maryland	
DATE REC'D BY LOCAL REGISTRAR 3 July 1955		REGISTRAR'S SIGNATURE Elizabeth B. Heck	
24. FUNERAL DIRECTOR C. M. Waltz, Winfield, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

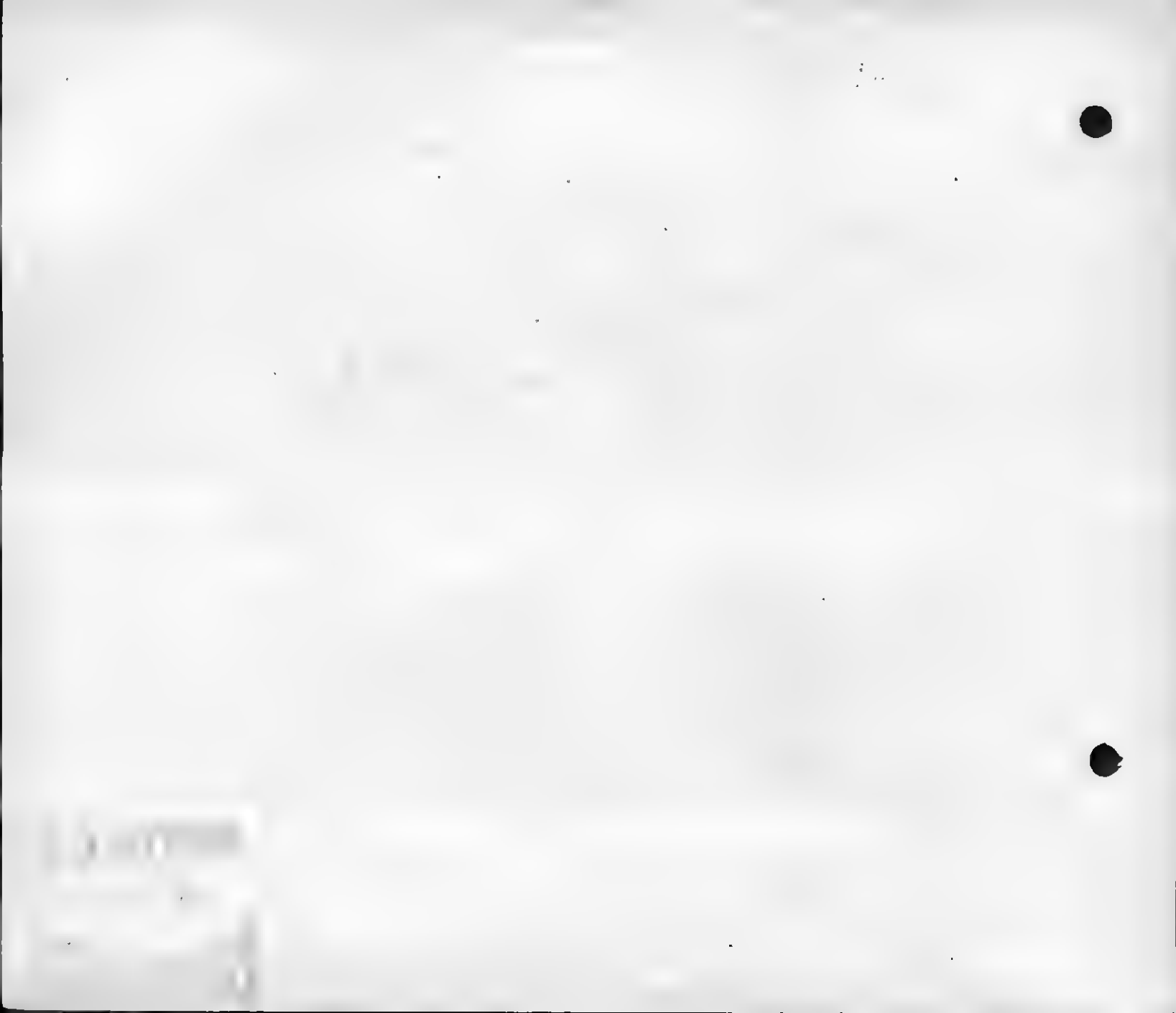
06678

# CERTIFICATE OF DEATH

Reg. Dist. No. 131

6647  
1415 - 6143 8/1/55

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Md</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>4 da.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont Rural</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Mem. Hospital</b>				STREET ADDRESS (If rural give location) <b>/</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Oscar Richard Saylor</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>7 23 1955</b>			
5. SEX: <b>M</b>		6. COLOR OR RACE: <b>W</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>MARRIED</b>		8. DATE OF BIRTH: <b>Dec. 5th. 1894</b>	
9. AGE last birthday: <b>60</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Clerk</b>		11. BIRTHPLACE (State or foreign country): <b>Frederick Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A</b>	
13. FATHER'S NAME: <b>Marshall Saylor</b>				14. MOTHER'S MAIDEN NAME: <b>Ellen Linn</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>No</b>				16. MEDICAL CERTIFICATION			
18. SOCIAL SECURITY NO. <b>204-16-7214</b>				17. INFORMANT & ADDRESS: <b>Elna Saylor Rocky Ridge Md</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE <b>44.3X</b>				<b>4 days</b>			
ANTECEDENT CAUSE (S)				<b>2 yrs.</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<b>10 yrs.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Chronic Bronchitis</b>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>7/20</b> , 1955, to <b>7/23</b> , 1955, that I last saw the deceased alive on <b>7/23</b> , 1955, and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Herry V. Chase</b>		DATE THEREOF <b>7/23/55</b>		NAME OF CEMETERY OR CREMATORY <b>Rocky Ridge Fredk Co. Md</b>		LOCATION (City, town, or county) (State)	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>July 26, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Rocky Ridge Fredk Co. Md</b>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <b>26 July 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabeth B. Hark</b>		24. FUNERAL DIRECTOR <b>M.L. Creager &amp; Son</b>		ADDRESS <b>Thurmont MD</b>	





6686

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u> <small>(If outside corporate limits, write RURAL and give nearest town)</small>	MARYLAND <small>LENGTH OF STAY (In this place)</small> <u>Life</u>	STATE <u>Maryland</u> COUNTY <u>Frederick</u> <small>(If outside corporate limits, write RURAL and give nearest town)</small>	<u>Adamstown</u>
TOWN <u>Adamstown</u>	HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>	STREET ADDRESS <small>(If rural give location)</small>	<u>1</u>
3. NAME OF DECEASED: (Type or Print) <u>JOHN</u> <u>FENTON</u> <u>SCARFF</u> <u>Jr.</u>		4. DATE (Month) (Day) (Year) OF DEATH. <u>July</u> <u>11</u> , <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. <del>SINGLE</del> <u>MARRIED</u> <del>WIDOWED</del> <u>DIVORCED</u> <small>(Specify)</small>	8. DATE OF BIRTH: <u>Married August 8, 1910</u>
9. AGE last birthday: <u>41</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Foreman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Painter</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John F. Scarff Sr.</u>		14. MOTHER'S MAIDEN NAME: <u>Grace Irene Rager</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-09-3521</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Helen P. Scarff, Adamstown, Maryland</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>420.1</u>		<u>2 years</u>	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) DUE TO <u>Coronary artery disease</u>			
(B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug. 1, 1953</u> , to <u>July 10, 1955</u> , that I last saw the deceased alive on <u>6-23, 1955</u> , and that death occurred at <u>10:45 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. B. Martin</u>		DATE SIGNED <u>7/12/1955</u>	
ADDRESS <u>Frederick, Maryland</u>		M. D. <u>Frederick, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 14, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>13 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Hack</u>	
24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WILLIAM H. H.

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6648

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Frederick</b>		LENGTH OF STAY (In this place) <b>Lifetime</b>		CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Memorial Hospital</b>				STREET ADDRESS (If rural give location) <b>203 West Second Street</b>			
3. NAME OF DECEASED:		(First) <b>FLORENCE</b>		(Middle) <b>GERTRUDE</b>		(Last) <b>SCHROEDER</b>	
4. DATE OF DEATH:		(Month) <b>July</b>		(Day) <b>27</b>		(Year) <b>1955</b>	
5. SEX: <b>Female</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>		8. DATE OF BIRTH: <b>June 7, 1900</b>	
9. AGE last birthday: <b>55</b> yrs.		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <b>Bank teller</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Frank J. Schroeder</b>				14. MOTHER'S MAIDEN NAME: <b>Lillie May Scholl</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>216-14-6042</b>		17. INFORMANT & ADDRESS: <b>Mrs. Robert L. Smith - Frederick, Md. (sister)</b>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
Immediate cause <b>170X Carcinoma of Rt. Breast</b>				<b>2 years</b>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.				<b>(b) Metastases to Lung and Bones</b>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Hypertrophic Arthritis</b>							
19a. DATE OF OPERATION: <b>July 3 1953</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Breast with Axillary Metastases</b>					
20. ACCIDENT SUICIDE HOMICIDE (Specify) <b>No</b>		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>h</b>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 25, 1953</b> , to <b>July 27, 1955</b> , that I last saw the deceased alive on <b>July 27, 1955</b> , and that death occurred at <b>1:05 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>W. A. Searre, M.D.</b>		ADDRESS <b>Frederick, Md.</b>		DATE SIGNED <b>7/28/55</b>			
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>July 29, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>28 July 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabeth B. Heck</b>		24. FUNERAL DIRECTOR <b>C. E. Cline &amp; Son - 8 East Patrick Street</b> <b>Frederick, Maryland</b>			

MARGIN RESERVE FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montg.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Frederick</u>	LENGTH OF STAY (in this place) <u>13 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Danascus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Mem. Hospital</u>	STREET ADDRESS (If rural give location) <u>15 X</u>		
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Madeline</u>	(Middle) <u>V.</u>	(Last) <u>Scott</u>	(Month) <u>July</u> (Day) <u>23</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. <u>SINGLE</u> MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 13, 1890</u>
9. AGE last birthday: <u>65</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Clarkesburg, Md.</u>	
11. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Louis Bell King</u>		14. MOTHER'S MAIDEN NAME: <u>Emma J. Hurley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Albert R. Scott, Danascus, Md.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>13 days</u>
Immediate cause (a) <u>Cerebral Thrombosis</u>		
Antecedent causes (s) (b) <u>DUE TO</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>		

11. OTHER SIGNIFICANT CONDITIONS		19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.						Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)			
SUICIDE	INJURY						
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?					

22. I hereby certify that I attended the deceased from <u>July 10, 1955</u> , to <u>July 23, 1955</u> , that I last saw the deceased alive on <u>July 23, 1955</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Bernard C. Thomas, M.D.</u>				ADDRESS <u>Frederick, Md.</u>		DATE SIGNED <u>July 23, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)				
<u>Burial</u>	<u>July 25, 1955</u>	<u>Danascus</u>	<u>Danascus, Montg. Co. Md.</u>				
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS					
<u>24 July 1955</u>	<u>Elizabeth S. Heck</u>	<u>Olin L. Molesworth, Danascus, Md.</u>					

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. GOVERNMENT

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## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Frederick</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Frederick</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>217 East Patrick Street</u>			STREET ADDRESS (If rural give location) <u>217 East Patrick Street</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WILLIAM HAROLD SCOTT, SR.</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>July 3, 1955</u>		
5. SEX: <u>Male</u>			6. COLOR OR RACE: <u>White</u>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>			8. DATE OF BIRTH: <u>17 Aug 1900</u>		
9. AGE last birthday: <u>54</u> yrs.			10. IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Railroad Company</u>		
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME: <u>Ulysses G. Scott, Sr.</u>			14. MOTHER'S MAIDEN NAME: <u>Alice Miles</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO: <u>705-05-5553</u>		
17. INFORMANT & ADDRESS: <u>217 E. Patrick St., Mrs. Madeline C. Scott, Frederick, Md.</u>					
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) DUE TO <u>Coronary Thrombosis</u>					<u>Sudden</u>
ANTECEDENT CAUSE (B) DUE TO <u>Arter. Sclerotic Heart Disease</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21C. WHERE DID (City or town) (County) (State)			21F. HOW DID INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from <u>6-10, 1955</u> to <u>July 3, 1955</u> , that I last saw the deceased alive on <u>July 1, 1955</u> , and that death occurred at <u>7:45 A</u> M, from the causes and on the date stated above.					
SIGNATURE <u>[Signature]</u>			DATE SIGNED <u>5 July 1955</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			DATE THEREOF <u>6 July 1955</u>		
NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>			LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>		
DATE REC'D BY LOCAL REGISTRAR <u>5 July 1955</u>			REGISTRAR'S SIGNATURE <u>[Signature]</u>		
24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			ADDRESS		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 6 1901



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

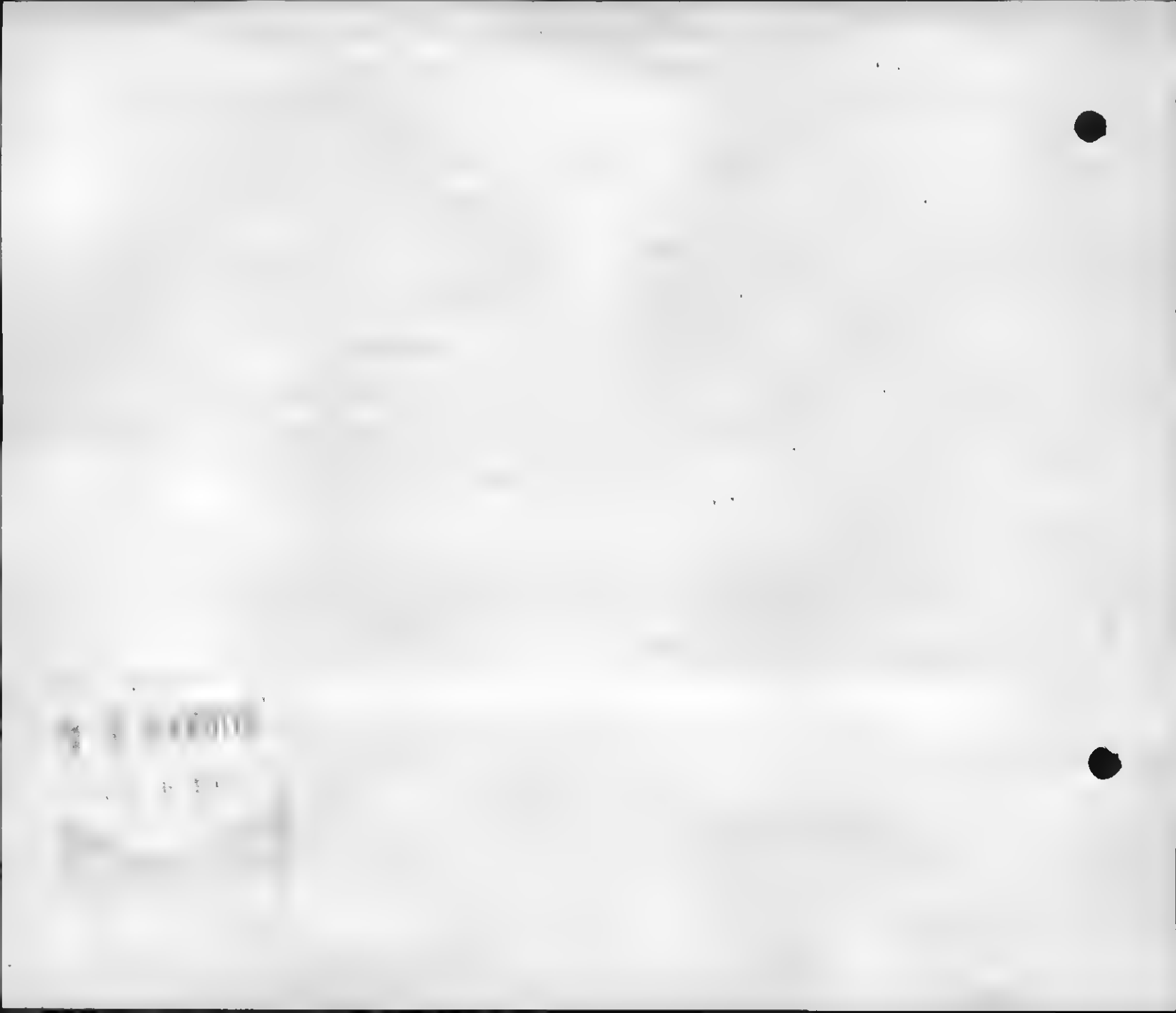
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## CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH: COUNTY Frederick MARYLAND CITY (If outside corporate limits, write RURAL OR TOWN) <u>Thurmont Rural</u> LENGTH OF STAY (If in place) <u>40 yrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Frederick CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Thurmont</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>01</u>		STREET ADDRESS (If rural give location) <u>Near Thurmont</u>	
3. NAME OF DECEASED: (Type or Print) <u>Assard</u> (First) (Middle) <u>Seipier</u> (Last)		4. DATE OF DEATH: <u>July 29</u> 19 <u>55</u>	
5. SEX. <u>male</u>	6. COLOR OR <u>white</u>	7. SINGLE, MARRIED, DIVORCED. <u>Married</u> (Specify)	8. DATE OF BIRTH <u>April 6, 1877</u>
9. AGE last birthday <u>78</u> yrs.		10. IF UNDER 1 YEAR: <u>Months</u> Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS <u>Saw Mill</u>	
11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George Seipier</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Feller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-07001</u>	
17. INFORMANT'S ADDRESS: <u>Mrs. Charles Carty Thurmont Rd I</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE <u>Pulmonary edema</u>			<u>3 hrs.</u>
(B) ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST <u>Chronic myocarditis</u>			<u>?</u>
(C) <u>Arteriosclerosis</u>			<u>?</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct. 7, 1947</u> to <u>July 29, 1955</u> , that I last saw the deceased alive on <u>July 29, 1955</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>M. J. Seipier</u>		DATE SIGNED <u>July 30, 1955</u>	
23. BURIAL, CREMATION, REINTERMENT (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug. 1 55</u>	<u>Blue Ridge Cemetery</u>	<u>Thurmont Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Aug. 1, 1955</u>	<u>Blanche S. Egler</u>	<u>M.L.C. Reager &amp; Son</u>	<u>Thurmont</u>



6638

## CERTIFICATE OF DEATH

Reg. Dist. No. 131.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Frederick</i>
<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <i>Middletown</i>	<i>10 yrs</i>	OR TOWN <i>Middletown</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Effie V. Shafer</i>		OF DEATH: <i>7 8 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<i>Female</i>	<i>white</i>	<i>married</i>	<i>4-5-1891</i>
9. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.		10. KIND OF BUSINESS OR INDUSTRY:	
<i>64 yrs.</i>		<i>own home</i>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Maryland</i>		<i>U. S.</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>George P. Stiles</i>		<i>Frances Sabington</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT'S ADDRESS:	
<i>no</i>		<i>Joseph Shafer, Middletown, Md.</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Coronary Thrombosis, acute.</i>			<i>1 hr</i>
ANTECEDENT CAUSE (S) (B) <i>arteriosclerosis, advanced,</i>			<i>?</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>generalized.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>July 8, 1955</i> , to <i>July 8, 1955</i> , that I last saw the deceased alive on <i>July 8, 1955</i> , and that death occurred at <i>10:30 P. M.</i> , from the causes and on the date stated above.			
SIGNATURE <i>Elizabeth C. Wilson</i>		DATE SIGNED <i>7/8/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>Lutheran Cemetery</i>	
DATE REC'D BY LOCAL REGISTRAR <i>11 July 1955</i>		REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>	
FUNERAL DIRECTOR <i>Bladhill Co.</i>		ADDRESS <i>Middletown, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. AIR FORCE

JUL 10 1955

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## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Frederick</u>	
<input checked="" type="checkbox"/> CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		<input checked="" type="checkbox"/> CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Burkittsville</u>				OR TOWN <u>Burkittsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
OF DECEASED: (Type or Print) <u>Harry P. Shafer</u>				OF DEATH: <u>7</u> <u>6</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>12-28-1870</u>	<u>84</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>machinist, etc.</u>				<u>farm</u>		<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Peter Shafer</u>				<u>Susan Kern</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>none</u>		<u>Mrs. Elizabeth Shafer, Burkittsville</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>443X</u> <u>Cardio. Renal Vascular disease</u>						<u>2 yrs.</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May</u> , 1955, to <u>July 6</u> , 1955, that I last saw the deceased alive on <u>July 4</u> , 1955, and that death occurred at <u>3:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J E Hoop</u>				ADDRESS <u>Middletown</u>		DATE SIGNED <u>7-7-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>7-8-1955</u>		<u>Lutheran Cemetery</u>	
24. FUNERAL DIRECTOR				LOCATION (City, town, or county)		(State)	
<u>Bladhill Co., Middletown, Md.</u>				<u>Middletown, Md.</u>		<u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		ADDRESS	
<u>8 July 1955</u>				<u>Elizabeth G. Heck</u>		<u>Bladhill Co., Middletown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 11 1955

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## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL or TOWN and give nearest town) <u>Frederick-Rural RD#5</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick-Rural RD#5</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rocky Springs</u>		STREET ADDRESS (If rural give location) <u>Rocky Springs</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>LESTER EZRA SHAFER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 4, 1955</u>	
5. SEX: <u>Male</u> 6. COLOR OR RACE: <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>25 Dec 1889</u> 9. AGE last birthday: <u>65</u> yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm Owner</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>George C. Shafer</u>		14. MOTHER'S MAIDEN NAME: <u>Laura Toms</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY NO.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Abbie F. Shafer, RD#5, Frederick, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>		<u>3 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Hypertensive arteriosclerotic heart disease</u>		<u>year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>MI</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>7/2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/29, 1953</u> , to <u>7/4, 1955</u> , that I last saw the deceased alive on <u>7/2, 1955</u> , and that death occurred at <u>4 A M</u> , from the causes and on the date stated above.			
SIGNATURE <u>James B. Thomas</u>		ADDRESS <u>M. D. Frederick, Maryland</u>	
DATE SIGNED <u>5 July 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7 July 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>	
24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. AIR FORCE  
OFFICE OF THE  
SECRETARY  
WASHINGTON, D.C.



6691

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

COUNTY Frederick MARYLAND  
 (If outside corporate limits, write RURAL OR and give nearest town)  
 TOWN Middletown  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Frederick  
 (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Middletown  
 STREET ADDRESS (If rural give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

CharlesE.Stine

## 4. DATE (Month)

(Day)

(Year)

OF DEATH: 741955

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

## 8. DATE OF BIRTH:

## 9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

malewhitewidowed1-30-187778 yrs.

Months Days Hours Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

## 10B. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY:

## 13. FATHER'S NAME:

Philip L. Stine

## 14. MOTHER'S MAIDEN NAME:

Laura Rautzahn

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

C. Glenn Stine, Middletown, Md.

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A)

DUE TO

## ANTECEDENT CAUSE (B)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.

(C)

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## INTERVAL BETWEEN ONSET AND DEATH

? 12 mo

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

1 March '55Carcinoma

## 20. AUTOPSY?

YES ☐ NO ☐

## 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1955, to July 4, 1955; that I last saw the deceased alive on July 3, 1955, and that death occurred at 7 P.M, from the causes and on the date stated above.

SIGNATURE

J. E. Harp

M. D.

ADDRESS

Middletown

DATE SIGNED

7-5-55

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

Burial7-7-1955Reformed CemeteryMiddletown, Md.7 July 1955Elizabeth B. HarpGladhill Co.Middletown, Md.

MARGIN RESERVED FOR BINDING

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11/11 1955

11/11 1955

6692

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
<del>OR</del> (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	<del>OR</del> (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Walkersville</u>	Years	TOWN <u>Walkersville</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pennsylvania Avenue</u>		STREET ADDRESS (If rural give location)	<u>Pennsylvania Avenue</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
(Type or Print) <u>CLAUDE WILLIAM STULL</u>		<u>July 12, 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. <del>SINGLE</del> MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
Male	White	Married	17 Dec 1900
9. AGE last birthday: <u>54</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Watkins Products</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Thomas M. Stull</u>		14. MOTHER'S MAIDEN NAME: <u>Minnie Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-2984</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Margaret W. Stull, Walkersville, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary thrombosis &amp; myocardial infarction</u>		10 min	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic CVD</u>		10 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes mellitus</u>		15 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic glomerular nephritis</u>		4 yrs	
19A. DATE OF OPERATION: <u>7</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1 April, 1949</u> , to <u>11 July, 1955</u> , that I last saw the deceased alive on <u>11 July, 1955</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Anna S. Stull Jr.</u>		DATE SIGNED <u>14 July 55</u>	
M.D. <u>Walkersville, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		<u>14 July 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Mount Olivet Cemetery</u>		<u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>14 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth D. Heck</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			

MARGIN RESERVED FOR BINDING

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[illegible]

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[illegible]

6651

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Frederick		LENGTH OF STAY (in this place) Since 2/21/48		OR (If outside corporate limits, write RURAL and give nearest town) TOWN Adamstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home for the Aged				STREET ADDRESS (If rural give location) X			
3. NAME OF DECEASED: (First) (Middle) (Last) CORR CORA BELLE THOMAS				4. DATE (Month) (Day) (Year) OF DEATH: July 3, 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: 30 Sept 1869	
9. AGE last birthday: 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-work		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Daniel Peter Thomas				14. MOTHER'S MAIDEN NAME: Elizabeth Rebecca Remsburg			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT & ADDRESS: Home for the Aged Records							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				5+ yrs.			
IMMEDIATE CAUSE (A) Arterio-sclerotic heart disease							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1950, to July, 1955, that I last saw the deceased alive on July, 1955, and that death occurred at 10 P. M. from the causes and on the date stated above.							
SIGNATURE Charles H. Conley		M. D. Frederick, Maryland		DATE SIGNED 5 July 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6 July 1955		NAME OF CEMETERY OR CREMATORY Reformed Cemetery		LOCATION (City, town, or county) (State) Church Hill-Fred'k Co. Md.	
DATE REC'D BY LOCAL REGISTRAR 6 July 1955		REGISTRAR'S SIGNATURE Elizabeth S. Hark		24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Fredenich</i> MARYLAND		STATE <i>Maryland</i> COUNTY		CITY (If outside corporate limits, write RURAL LENGTH OF STREET OR TOWN and give nearest town) <i>Baltimore</i>		STREET ADDRESS (If rural give location) <i>Vanadena Con. Home</i>	
3. NAME OF DECEASED: (First) <i>Fannetta</i> (Middle) (Last) <i>Turner</i>				4. DATE OF DEATH: (Month) <i>July</i> (Day) <i>24</i> (Year) <i>1955</i>			
5. SEX: <i>female</i>		6. COLOR OR RACE: <i>white</i>		7. SINGLE, MARRIED, WIDOWED, <del>DIVORCED</del> , (Specify): <i>widowed</i>		8. DATE OF BIRTH: <i>Mar 1 1877</i>	
9. AGE last birthday: <i>78</i> yrs.		10. BIRTHPLACE (State or foreign country): <i>Maryland</i>		11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <i>James Moley</i>				14. MOTHER'S MAIDEN NAME: <i>Emily Todd</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Mrs. Dan Weinberg</i>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<p>Immediate cause (a) <i>Acute left side heart failure &amp; pulmonary edema</i> 1 hr</p> <p>Antecedent causes (s) (b) <i>Hypertensive cardiovascular disease</i> 8 year plus</p> <p>DUE TO (c)</p>							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. <i>Cerebral thrombosis with right hemiplegia</i>							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>March 1955</i> , to <i>July 24, 1955</i> , that I last saw the deceased alive on <i>July 24, 1955</i> , and that death occurred at <i>11:00 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>L. L. Schoolman M.D.</i>				ADDRESS <i>228 N. Market St. Frederick</i>		DATE SIGNED <i>7/24/55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>7/27/55</i>		<i>Jordan Park</i>		<i>Baltimore Md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>25 July 1955</i>		<i>Elizabeth S. Heck</i>		<i>L. E. Carlyle</i>		<i>Fredenich Md</i>	

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## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> <u>Rural - Braddock</u>		<u>2 yrs.</u>		<u>Rural - Utica</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>ISABELLE WACHTER</u>				<u>July 27 1955</u>			
5. SEX. <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>—</u>	
9. AGE last birthday: <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Leuhart</u>				14. MOTHER'S MAIDEN NAME: <u>Rebecca Baker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Mrs. Albert J. Main, Fred - R.F. 105.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						10 days	
IMMEDIATE CAUSE (A) <u>Pneumonia,</u>						10 days	
ANTECEDENT CAUSE (B) <u>Generalized arteriosclerosis</u>						Years.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 1955, to July 27, 1955, that I last saw the deceased alive on July 27, 1955, and that death occurred at 11:50 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Robert S. Turner, Jr.</u>				ADDRESS <u>7 E. Church St. Frederick, Md.</u>		DATE SIGNED <u>7-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/30/55</u>		<u>Utica Lutheran</u>		<u>Utica Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>29 July 1955</u>		<u>Elizabeth B. Heck</u>		<u>T.C. Barton, Walkersville, Md.</u>			

MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06692  
 Item 18, Film G184, Item 8, Film 184 8-4-55 et  
**CERTIFICATE OF DEATH**

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR Frederick	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR Point of Rocks	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) EULICE (Middle) DEXTER (Last) WALLACE		4. DATE OF DEATH: July 12, 1955	
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 1892 December 5, 1892
9. AGE last birthday: 62 yrs.		10. IF UNDER 1 YEAR: Months: Days: Hours: Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY: B. & O. R.R.	
11. FATHER'S NAME: Thomas Wallace		12. MOTHER'S MAIDEN NAME: Lucy Unknown	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		14. SOCIAL SECURITY No.	
15. INFORMANT & ADDRESS: Mrs. Sarah F. Wallace, Point of Rocks, Md.		16. CITIZEN OF WHAT COUNTRY? USA	
17. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
342 X Immediate cause (a) Encephalomyelitis, etiology undetermined, question viral		12 days	
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO			
(c)			
11. OTHER SIGNIFICANT CONDITIONS		Unk.	
Conditions contributing to the death but not related to the disease or condition causing death. Bronchiectasis			
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes XX No	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work Not While At Work	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1, 1955, to July 12, 1955, that I last saw the deceased alive on July 12, 1955, and that death occurred at 8:30 P.M., from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
Burial		Fairview Cemetery	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
14 July 1955		Frederick, Maryland	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
Elizabetta B. Hetch		ADDRESS	
		M. R. Etchison & Son, Frederick, Maryland	



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UNIVERSITY OF CALIFORNIA

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore City</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Cullen</b>		<b>3535 days.</b>		OR TOWN <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hospital</b>				STREET ADDRESS (If rural give location) <b>2932 Edmonston Avenue</b>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <b>William</b>		(Middle) <b>C.</b>		(Last) <b>Walter</b>		(Day) <b>4</b> (Year) <b>1955</b>	
(Type or Print)							
5. SEX.	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>Male</b>	<b>White</b>	<b>Single</b>	<b>June 9, 1882</b>	<b>73</b> yrs	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Ship Rigger</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>Ship Rigger</b>		11. BIRTHPLACE (State or foreign country): <b>Baltimore, Md.</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME: <b>Charles J. Walter</b>				14. MOTHER'S MAIDEN NAME: <b>Amanda Poulton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>Yes World War I</b>				16. SOCIAL SECURITY NO. <b>213-10-9569</b>		17. INFORMANT & ADDRESS: <b>Patient</b>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Pulmonary Tuberculosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>11 years.</b>			
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>0</b>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Oct. 29, 1945</b> , to <b>July 4, 1955</b> , that I last saw the deceased alive on <b>July 4, 1955</b> , and that death occurred at <b>1:05 M.</b> from the causes and on the date stated above.							
SIGNATURE <b>[Signature]</b>				A.M. ADDRESS <b>Cullen, Md.</b>		DATE SIGNED <b>July 5, 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				DATE THEREOF <b>7-6-55</b>		NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	
						LOCATION (City, town, or county) <b>Balto., Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>7/5/55</b>				REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR <b>Mr. Ticmer &amp; Sons</b>	
						ADDRESS	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06694  
6653 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frederick</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial</u>		STREET ADDRESS (If rural give location) <u>90 Lincoln Apartments</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WARS</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>July 2 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>July 1, 1955</u>
9. AGE last birthday <u>15</u> yrs.		10. AGE last birthday <u>15</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Infant</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>ERLEST MCKINLEY TURNER</u>		14. MOTHER'S MAIDEN NAME: <u>FRANCES ELIZABETH INGRAM</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>90 Lincoln Apts., Mrs. Frances E. Wars, Frederick, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Congestive Heart Disease</u>			<u>15 hours</u>
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1955</u> , to <u>July 2, 1955</u> ; that I last saw the deceased alive on <u>July 2, 1955</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Bernard Thomas Jr.</u>		ADDRESS <u>Frederick, Md.</u> DATE SIGNED <u>July 2, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2 July 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		LOCATION (City, town, or county) (State) <u>Frederick - Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Hick</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Charles E. Hicks III Fred. Md.</u>	

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5. 11. 1971  
10. 11. 1971



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 18 Film G185 8-12-55 ams

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## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>13 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Emmitsburg, Md.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick City Hospital</b>				STREET ADDRESS (If rural give location) <b>Emmitsburg, R.D.# 3</b>			
3. NAME OF DECEASED: (Type or Print) <b>William Guy Wetzel</b>				4. DATE OF DEATH: <b>July 23 1955</b>			
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED <b>Married</b>		8. DATE OF BIRTH: <b>May 13, 1905</b>	
9. AGE last birthday: <b>50</b> yrs.		10. MONTHS: <b>5</b>		11. DAYS: <b>23</b>		12. HOURS: <b>19</b>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <b>Grit Mill</b>				10b. KIND OF BUSINESS OR INDUSTRY: <b>Driller</b>			
11. BIRTHPLACE (State or foreign country): <b>Emmitsburg, Frederick Co</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME: <b>Edward Wetzel</b>				14. MOTHER'S MAIDEN NAME: <b>Lucy Tressler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>				16. SOCIAL SECURITY No.: <b>220-10-5825</b>		17. INFORMANT & ADDRESS: <b>Roseba A. Wetzel, Emmitsburg, R.D.3 Md.</b>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
104-1 Immediate cause (a) <b>Bronchopneumonia</b>						<b>1 Day</b>	
Antecedent causes (s) (b) <b>Histological lesions typical of</b>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <b>Rocky Mountain Spotted Fever</b>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Pneumoconiosis</b>							
19a. DATE OF OPERATION: <b>2</b> 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 9, 1955</b> , to <b>July 23, 1955</b> , that I last saw the deceased alive on <b>July 23, 1955</b> , and that death occurred at <b>1:30 pm</b> , from the causes and on the date stated above.							
SIGNATURE <b>J. W. Schorham</b>				ADDRESS <b>225 N. Main St. Emmitsburg, Md.</b>		DATE SIGNED <b>7/24/55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>July 26, 1955</b>		<b>Friends Creek</b>		<b>Emmitsburg, R.D.2 Md.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>26 July 1955</b>		<b>Elizabeth S. Heck</b>		<b>S. L. Allison</b>		<b>Emmitsburg, Md.</b>	
S. L. Allison							

BUREAU V. S.

JUL 29 1955

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## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>27 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>106 Pennsylvania Avenue</u>				STREET ADDRESS (If rural give location) <u>106 Pennsylvania Avenue</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>ROSALIE</u>		(Middle) <u>DEA</u>		(Last) <u>ZEPP</u>		(Month) (Day) (Year) <u>July 30 1955</u>	
(Type or Print)							
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>September 28, 1879</u>	9. AGE last birthday: <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>William O. Fish</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Ann McMahon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>214-10-2456</u>		17. INFORMANT & ADDRESS: <u>Mr. William T. Zepp - Frederick, Maryland</u>			
(If Yes, give war or dates of service)							

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<u>443x</u> Immediate cause (a) <u>Subarachnoid hemorrhage</u>				<u>2 days</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u>				<u>10 yrs +</u>	
(c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>OF INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec</u> , 19 <u>53</u> , to <u>July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 29</u> , 19 <u>55</u> , and that death occurred at <u>12:45 A.M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Leroy V. Chase M.D.</u>		ADDRESS <u>4 E. Church St. Frederick</u>		DATE SIGNED <u>8/1/55</u>	
23. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		DATE THEREOF <u>August 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>		DATE REC'D BY LOCAL REGISTRAR <u>1 August 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heisk</u>	
24. FUNERAL DIRECTOR <u>C. E. Cline &amp; Son - 8 East Patrick Street</u>		ADDRESS <u>Frederick, Maryland</u>			

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 3 1956

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